

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HELEN HAFER ANDREWS			2a. DATE OF DEATH MONTH DAY YEAR April 6, 1984		2b. HOUR M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 9, 1902	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.		
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1134 Luther Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School
13a. STATE MARYLAND	13b. COUNTY WASH.	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1134 Luther Dr. 21740	
14. FATHER'S NAME GEORGE WASHINGTON		15. MOTHER'S MAIDEN NAME MARIA MCCULLOUGH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-36-3717		17. INFORMANT ADDRESS DAVID ANDREWS 5110 Foxville, Smithsburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: congestive heart failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1 , 19 79 , to 4/6 , 19 84 , that (I) (we) last saw the deceased alive on 3 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE George Newman II		DEGREE M.D.		22c. DATE SIGNED 4/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE C. NEWMAN, II, M.D.		22e. ADDRESS 1825 HOWELL RD. HAGERSTOWN, MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4/9/84	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN WASH MD	
24. FUNERAL DIRECTOR REST HAVEN FUNERAL CHAPEL		ADDRESS 1601 Pennsylvania Ave. Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR APR 12 1984	
		25b. REGISTRAR'S SIGNATURE Felix Davidson Rodell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

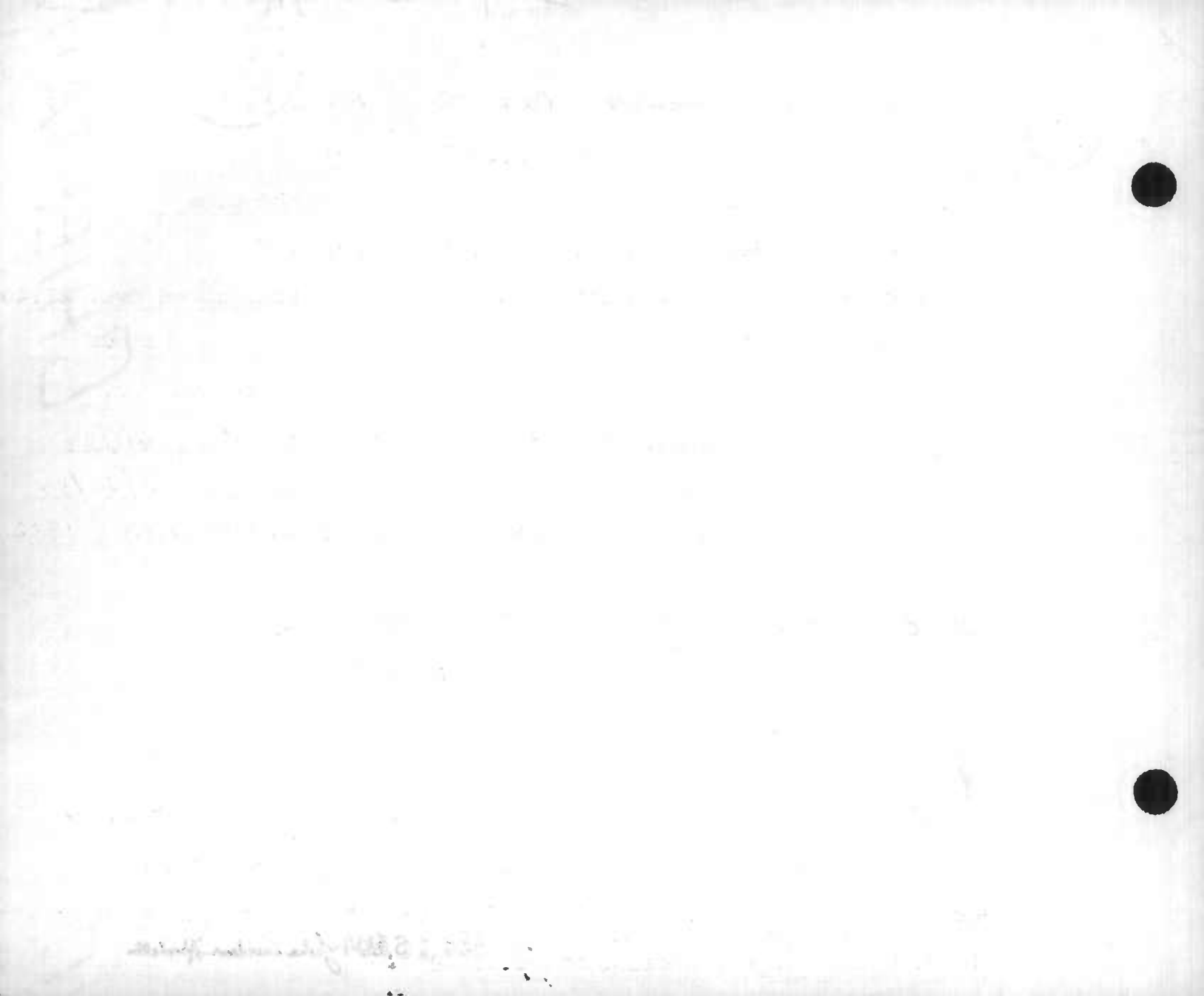
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSETTA HELEN ARTHUR				2b. HOUR MIN. 3:05 P.M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1902		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 125 Fairground Ave. 21740		14. FATHER'S NAME FIRST MIDDLE LAST Herbert Poffenberger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Danner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-9277		17. INFORMANT ADDRESS Glory L. Huff, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 5621 DUE TO, OR AS A CONSEQUENCE OF (b) LARGE BOWEL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE AND CHRONIC SIGMOID DIVERTICULITIS 1982 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/1/84 3/20/84	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION MARCH 25 1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED LARGE BOWEL OBSTRUCTION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NONE			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Francisco G. Japzon MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCISCO G JAPZON MD		22e. ADDRESS 445 E. FIRST ST. HAGERSTOWN, MD. 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 13, 1984		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740							



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DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.														
1. FOR STATE REGISTRAR					7a. DATE OF DEATH MONTH DAY YEAR 4 17 1984							7b. HOUR P 1:13 M												
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louise Elizabeth Bailey					3. SEX Female					4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 25 13		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.												
10. CITY OR TOWN OF DEATH Hagerstown					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK					12b. KIND OF BUSINESS OR INDUSTRY CAFETERIA									
13a. STATE Maryland					13b. CITY OR TOWN Washington					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET ADDRESS / ZIP CODE 1109 Fairview Road 21740									
14. FATHER'S NAME FIRST MIDDLE LAST NOAH HINES					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA PLUNKET					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 214-09-4842					17. INFORMANT ADDRESS 2909 Markley Ave. Albertus Bailey, Jr. Baltimore, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular tachycardia/Fibrillation</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive & Atherosclerotic Heart Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10-15 Minutes 30 Minutes														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Pulmonary emphysema; diabetes mellitus; osteoarthritis & osteoporosis</u>																								
19a. DATE OF OPERATION None					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (the doctor) attended the deceased from April 12, 1984, to April 17, 1984, that (I) saw the deceased alive on April 17, 1984, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) view the body after death.																								
22b. SIGNATURE W. T. Layman, M.D.										DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 4/18/84									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. T. Layman, M.D.										22e. ADDRESS 301 E. Antietam St., Hagerstown, MD. 21740														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					23b. DATE 4/20/84					23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.					23d. LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN WASH. MD									
24. FUNERAL DIRECTOR REST HAVEN FUNERAL CHAPEL, INC. 1601 Pennsylvania Ave. Hagerstown, Md.																								

DATE RECEIVED BY REGISTRAR 75b. REGISTRAR'S SIGNATURE

APR 23 1984 Julia Davidson-Rodell



APR 23 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1- FOR STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Jettie Marie Bellomo					2a. DATE OF DEATH MONTH DAY YEAR 4-27-84					2b. HOUR 11:40 AM				
3. SEX female			4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 14, 1914			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 467 McDowell Avenue 21740					
14. FATHER'S NAME FIRST MIDDLE LAST Millard Garrett					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 214-09-4447		17. INFORMANT ADDRESS Mrs. Marlene E. Commer, Williamsport, MD.							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Degenerative Changes</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Alcohol Abuse</u>														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-27-84</u> 19 <u>17</u> to <u>4-27</u> 19 <u>84</u> , that (I) (we) lost <u>above</u> the deceased alive on <u>4-27-84</u> 19 <u>17</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)														
22b. SIGNATURE <u>E. J. Lindberg</u> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 4-28-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. J. Lindberg					22e. ADDRESS 387 South Park Blvd. Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial					23b. DATE May 1, 1984		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland				
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME										25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR MAY 02 1984				
415 E. Wilson Blvd., Hagerstown, Maryland 21740														

BP _____

21st of March 1941
S. O. YAM

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

11788

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William Edgar BENDER			2a. DATE OF DEATH MONTH DAY YEAR April 10, 1984			2b. HOUR M AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 22, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH Sharpsburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 104 West Chapline Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fabricator		12b. KIND OF BUSINESS OR INDUSTRY Leather	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 104 W. Chapline St. / 21782		14. FATHER'S NAME FIRST MIDDLE LAST Charles Edgar Bender					
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes May Stull		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-5795		17. INFORMANT ADDRESS Betsy R. Bender (item 13 above)					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

4960

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

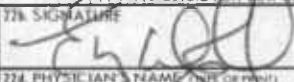
(b) **Cachexia**


DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

MEDICAL CERTIFICATION

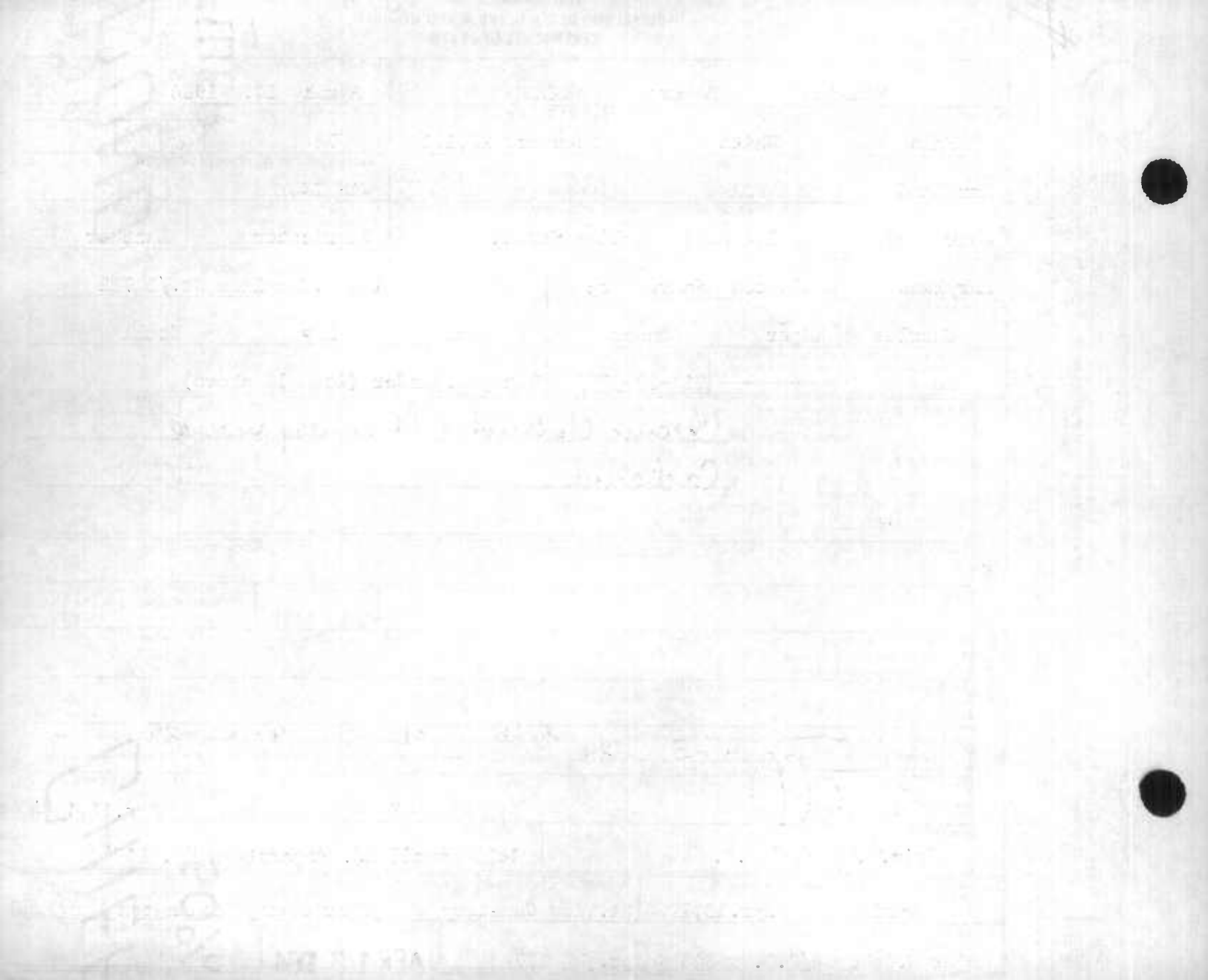
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 8-26 , 19 81 , to 4-10 , 19 84 , that (I) (we) last saw the deceased alive on 4-2 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not see the body after death.)							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Apr. 11, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric M. Wagshal, M.D.				22e. ADDRESS 1825 Howell Rd. Hagerstown, MD. 21740			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 13, 1984		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sharpsburg Washington Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Major M. Osborne / P.O. Bx #348 Wmspt., MD 21795				25a. DATE REC'D. BY REGISTRAR APR 13 1984		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payer may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Payer and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1. STATE REGISTRAR					STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) Tanya Lynn BIRCKHEAD					2a DATE OF DEATH MONTH . DAY YEAR 4 15 84					2b HOUR 5:00 M				
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR April 15 1984			6 AGE (IN YEARS LAST BIRTHDAY) none YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? US			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.						
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none			12b. KIND OF BUSINESS OR INDUSTRY none				
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 406 Park Place 21740						
14 FATHER'S NAME FIRST MIDDLE LAST John NMN Birkhead					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Catherine Cook									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no		17 INFORMANT ADDRESS Mother Virginia Catherine Cook 406 Park Place										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7485 IMMEDIATE CAUSE (a) Hypoplastic Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Immaturity DUE TO, OR AS A CONSEQUENCE OF (c) Premature Labor										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 4/15 1984 to 4/15 1984, that (I) (we) last saw the deceased alive on 4/15 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Frederick D. Dove Jr. M.D.										DEGREE M.D.		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick D. Dove Jr. M.D.										22e. ADDRESS Hagerstown, Maryland				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					23b. DATE 4/19/84		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN WASH MD			
24. FUNERAL DIRECTOR REST HAVEN FUNERAL CHAPEL, INC 1601 Pennsylvania Ave. Hagerstown, Md														
25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE APR 23 1984 John Trivette				

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Handwritten text, possibly a signature or name, appearing in the center of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 not, any injury, or other traumatic event, then medical examiner will be notified to give an autopsy.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		
PAUL W. Bittinger			4/1/84 3:30 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		
Male	White	July 17, 1907	76		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Penna.	U.S.A.		Washington MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Western Maryland Center		Truck Driver		Feed Store
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Pa.			Franklin	Chambersburg	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
William H. Bittinger			Elizabeth Kelso		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		
NO			175-03-4207		
17. INFORMANT			ADDRESS		
Paul S. Bittinger			1328 Pleasant Veiw Dr. Chambg. Pa. 17201		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Chronic Renal Failure					years
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetic Nephropathy					years
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
Hypertensive Arteriosclerotic Cardiovascular Disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 4/1/84 to 4/1/84, that (we) lost saw the deceased alive on 4/1/84, and that in (my) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE		DEGREE	22c. DATE SIGNED		
Rose Marie Chan		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	4/1/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ROSE MARIE CHAN, M.D.		Western Maryland Center, Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	4/3/84	Air Hill Cemetery	Greene Twn. Franklin Co. Pa.		
24. FUNERAL DIRECTOR NAME		25a. DATE REG. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
R.G. Sellers F/H Inc.		APR 5 1984		The Honorable Justice	
ADDRESS					
297 Phila. Ave. Chambg.					



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ATA

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY		MIDDLE Julia		LAST BORKOWSKI		2a. DATE KNOWN OF DEATH		X MONTH DAY YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		12c. HOUR	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
PART I DEATH WAS CAUSED BY:		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection	
IMMEDIATE CAUSE (a)		WHILE AT WORK		STREET, FACTORY, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		death resulted from:		Inquiry		and in my opinion	
DUE TO, OR AS A CONSEQUENCE OF		NOT WHILE AT WORK		(AT HOME, STREET, FACTORY, FARM, ETC.)		505 W Church St Hagerstown WASH MD		Natural causes		X		Undetermined manner	
(b)		22b. I certify that I took charge of the remains described above, held on		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION		22e. DATE		Autopsy		Inspection		Inquiry	
(c)		22e. DATE		22f. NAME OF CEMETERY OR CREMATORY		22g. LOCATION		Autopsy		Inspection		Inquiry	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		22f. NAME OF CEMETERY OR CREMATORY		22g. LOCATION		22h. DATE		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22h. DATE		22i. NAME OF CEMETERY OR CREMATORY		22j. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22i. NAME OF CEMETERY OR CREMATORY		22j. LOCATION		22k. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22j. LOCATION		22k. DATE		22l. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22k. DATE		22l. NAME OF CEMETERY OR CREMATORY		22m. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22l. NAME OF CEMETERY OR CREMATORY		22m. LOCATION		22n. DATE		Autopsy		Inspection		Inquiry	
(c)		22m. LOCATION		22n. DATE		22o. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22n. DATE		22o. NAME OF CEMETERY OR CREMATORY		22p. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22o. NAME OF CEMETERY OR CREMATORY		22p. LOCATION		22q. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22p. LOCATION		22q. DATE		22r. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22q. DATE		22r. NAME OF CEMETERY OR CREMATORY		22s. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22r. NAME OF CEMETERY OR CREMATORY		22s. LOCATION		22t. DATE		Autopsy		Inspection		Inquiry	
(c)		22s. LOCATION		22t. DATE		22u. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22t. DATE		22u. NAME OF CEMETERY OR CREMATORY		22v. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22u. NAME OF CEMETERY OR CREMATORY		22v. LOCATION		22w. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22v. LOCATION		22w. DATE		22x. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22w. DATE		22x. NAME OF CEMETERY OR CREMATORY		22y. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22x. NAME OF CEMETERY OR CREMATORY		22y. LOCATION		22z. DATE		Autopsy		Inspection		Inquiry	
(c)		22y. LOCATION		22z. DATE		22aa. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22z. DATE		22aa. NAME OF CEMETERY OR CREMATORY		22ab. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22aa. NAME OF CEMETERY OR CREMATORY		22ab. LOCATION		22ac. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22ab. LOCATION		22ac. DATE		22ad. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22ac. DATE		22ad. NAME OF CEMETERY OR CREMATORY		22ae. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22ad. NAME OF CEMETERY OR CREMATORY		22ae. LOCATION		22af. DATE		Autopsy		Inspection		Inquiry	
(c)		22ae. LOCATION		22af. DATE		22ag. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22af. DATE		22ag. NAME OF CEMETERY OR CREMATORY		22ah. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22ag. NAME OF CEMETERY OR CREMATORY		22ah. LOCATION		22ai. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22ah. LOCATION		22ai. DATE		22aj. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22ai. DATE		22aj. NAME OF CEMETERY OR CREMATORY		22ak. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22aj. NAME OF CEMETERY OR CREMATORY		22ak. LOCATION		22al. DATE		Autopsy		Inspection		Inquiry	
(c)		22ak. LOCATION		22al. DATE		22am. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22al. DATE		22am. NAME OF CEMETERY OR CREMATORY		22an. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22am. NAME OF CEMETERY OR CREMATORY		22an. LOCATION		22ao. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22an. LOCATION		22ao. DATE		22ap. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22ao. DATE		22ap. NAME OF CEMETERY OR CREMATORY		22aq. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22ap. NAME OF CEMETERY OR CREMATORY		22aq. LOCATION		22ar. DATE		Autopsy		Inspection		Inquiry	
(c)		22aq. LOCATION		22ar. DATE		22as. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22ar. DATE		22as. NAME OF CEMETERY OR CREMATORY		22at. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22as. NAME OF CEMETERY OR CREMATORY		22at. LOCATION		22au. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22at. LOCATION		22au. DATE		22av. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22au. DATE		22av. NAME OF CEMETERY OR CREMATORY		22aw. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22av. NAME OF CEMETERY OR CREMATORY		22aw. LOCATION		22ax. DATE		Autopsy		Inspection		Inquiry	
(c)		22aw. LOCATION		22ax. DATE		22ay. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22ax. DATE		22ay. NAME OF CEMETERY OR CREMATORY		22az. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22ay. NAME OF CEMETERY OR CREMATORY		22az. LOCATION		22ba. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22az. LOCATION		22ba. DATE		22bb. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22ba. DATE		22bb. NAME OF CEMETERY OR CREMATORY		22bc. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22bb. NAME OF CEMETERY OR CREMATORY		22bc. LOCATION		22bd. DATE		Autopsy		Inspection		Inquiry	
(c)		22bc. LOCATION		22bd. DATE		22be. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22bd. DATE		22be. NAME OF CEMETERY OR CREMATORY		22bf. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22be. NAME OF CEMETERY OR CREMATORY		22bf. LOCATION		22bg. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22bf. LOCATION		22bg. DATE		22bh. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22bg. DATE		22bh. NAME OF CEMETERY OR CREMATORY		22bi. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22bh. NAME OF CEMETERY OR CREMATORY		22bi. LOCATION		22bj. DATE		Autopsy		Inspection		Inquiry	
(c)		22bi. LOCATION		22bj. DATE		22bk. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22bj. DATE		22bk. NAME OF CEMETERY OR CREMATORY		22bl. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22bk. NAME OF CEMETERY OR CREMATORY		22bl. LOCATION		22bm. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22bl. LOCATION		22bm. DATE		22bn. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22bm. DATE		22bn. NAME OF CEMETERY OR CREMATORY		22bo. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22bn. NAME OF CEMETERY OR CREMATORY		22bo. LOCATION		22bp. DATE		Autopsy		Inspection		Inquiry	
(c)		22bo. LOCATION		22bp. DATE		22bq. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22bp. DATE		22bq. NAME OF CEMETERY OR CREMATORY		22br. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22bq. NAME OF CEMETERY OR CREMATORY		22br. LOCATION		22bs. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22br. LOCATION		22bs. DATE		22bt. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22bs. DATE		22bt. NAME OF CEMETERY OR CREMATORY		22bu. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22bt. NAME OF CEMETERY OR CREMATORY		22bu. LOCATION		22bv. DATE		Autopsy		Inspection		Inquiry	
(c)		22bu. LOCATION		22bv. DATE		22bw. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22bv. DATE		22bw. NAME OF CEMETERY OR CREMATORY		22bx. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22bw. NAME OF CEMETERY OR CREMATORY		22bx. LOCATION		22by. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22bx. LOCATION		22by. DATE		22bz. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22by. DATE		22bz. NAME OF CEMETERY OR CREMATORY		22ca. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22bz. NAME OF CEMETERY OR CREMATORY		22ca. LOCATION		22cb. DATE		Autopsy		Inspection		Inquiry	
(c)		22ca. LOCATION		22cb. DATE		22cc. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22cb. DATE		22cc. NAME OF CEMETERY OR CREMATORY		22cd. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22cc. NAME OF CEMETERY OR CREMATORY		22cd. LOCATION		22ce. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22cd. LOCATION		22ce. DATE		22cf. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22ce. DATE		22cf. NAME OF CEMETERY OR CREMATORY		22cg. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22cf. NAME OF CEMETERY OR CREMATORY		22cg. LOCATION		22ch. DATE		Autopsy		Inspection		Inquiry	
(c)		22cg. LOCATION		22ch. DATE		22ci. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22ch. DATE		22ci. NAME OF CEMETERY OR CREMATORY		22cj. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22ci. NAME OF CEMETERY OR CREMATORY		22cj. LOCATION		22ck. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22cj. LOCATION		22ck. DATE		22cl. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22ck. DATE		22cl. NAME OF CEMETERY OR CREMATORY		22cm. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22cl. NAME OF CEMETERY OR CREMATORY		22cm. LOCATION		22cn. DATE		Autopsy		Inspection		Inquiry	
(c)		22cm. LOCATION		22cn. DATE		22co. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22cn. DATE		22co. NAME OF CEMETERY OR CREMATORY		22cp. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22co. NAME OF CEMETERY OR CREMATORY		22cp. LOCATION		22cq. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22cp. LOCATION		22cq. DATE		22cr. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22cq. DATE		22cr. NAME OF CEMETERY OR CREMATORY		22cs. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22cr. NAME OF CEMETERY OR CREMATORY		22cs. LOCATION		22ct. DATE		Autopsy		Inspection		Inquiry	
(c)		22cs. LOCATION		22ct. DATE		22cu. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
PT fell fracturing her left hip & arm		22ct. DATE		22cu. NAME OF CEMETERY OR CREMATORY		22cv. LOCATION		Autopsy		Inspection		Inquiry	
4360 Cerebral VAS. Accident		22cu. NAME OF CEMETERY OR CREMATORY		22cv. LOCATION		22cw. DATE		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22cv. LOCATION		22cw. DATE		22cx. NAME OF CEMETERY OR CREMATORY		Autopsy		Inspection		Inquiry	
Hyper-tensive arterioscl. disease		22cw. DATE		22cx. NAME OF CEMETERY OR CREMATORY		22cy. LOCATION		Autopsy		Inspection		Inquiry	
DUE TO, OR AS A CONSEQUENCE OF		22cx. NAME OF CEMETERY OR CREMATORY		22									

APR 30 1964

REG. NO.

MEDICAL CERTIFICATION

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/B2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

1. *Thymus* 1907 2. *Yan*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMM - 16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as being an injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZABETH MARIE BUEHLER					2a. DATE OF DEATH MONTH DAY YEAR 4 25 84 2b. HOUR 2 00 AM				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1906		6. AGE (IN YEARS (LAST BIRTHDAY)) 77 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Washington Williamsport					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21795 Homewood Ret. Ctr. Apt. 310		
14. FATHER'S NAME FIRST MIDDLE LAST George Quiner					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Applonia Huber				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 213-74-4969		17. INFORMANT ADDRESS Albert L. Buehler, Williamsport Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Myocardial infarction, severe hypertension									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 8/1 , 19 83 , to 4/25 , 19 84 , the (I) (we) lost saw the deceased alive in March , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (a) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Allen W. Ditt			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/25/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen W. Ditt M.D.			22e. ADDRESS 1610 Oakview Ave. Hagerstown Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE Apr. 26, 1984		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Wash., Md.		
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 30 1984 Julia Davidson-Randall				
415 E. Wilson Blvd., Hagerstown, Md. 21740									

88

HOUSTON, TEXAS

TO THE
HONORABLE
MEMBERS OF THE
LEGISLATURE

OF THE
STATE OF TEXAS

IN SENATE

COMMITTEE ON

EDUCATION

REPORT

APR 30 1901

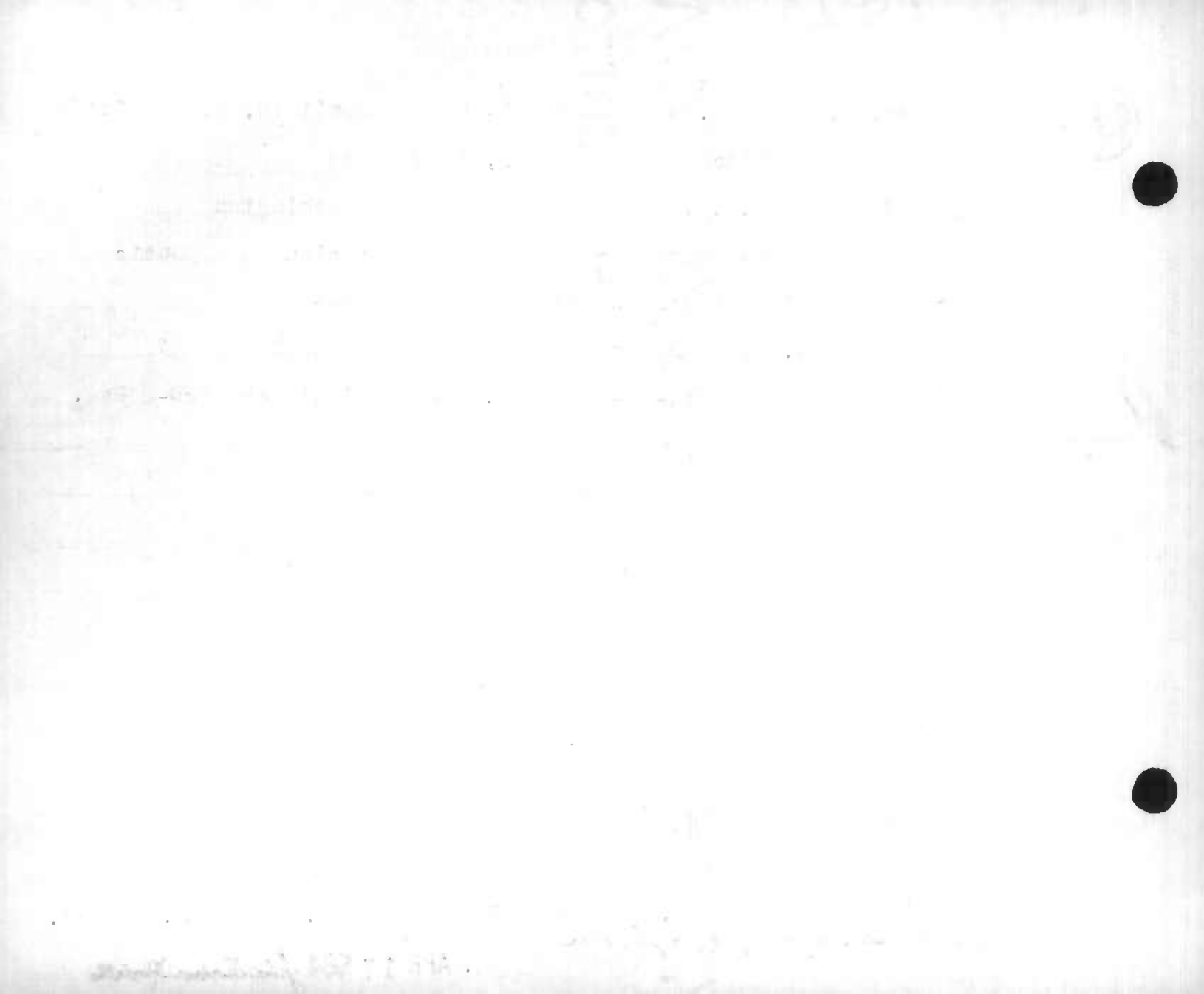
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Adelbert E. Burton			2a. DATE OF DEATH MONTH DAY YEAR April 10, 84		2b. HOUR 3:15P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 22, 1904		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RFD-2 Hagerstown		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician		12b. KIND OF BUSINESS OR INDUSTRY Music	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John A. Burton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Edith ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17. INFORMANT ADDRESS Mrs. Evelyn Wissinger RFD-2 Hag.	
18a. SOCIAL SECURITY NO. 214-09-3021		18b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinoma DUE TO, OR AS A CONSEQUENCE OF: (b) Carcinoma of colon DUE TO, OR AS A CONSEQUENCE OF: (c) 1539		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 1 yr.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 83 to April 10 19 84 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E Hoachler		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E Hoachler		22e. ADDRESS Hagerstown Md					
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE April 13, 84		23c. NAME OF CEMETERY OR CREMATORY Rose Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Hag. Wash. Md.	
24. FUNERAL HOME Thompson Funeral Home		24a. DATE REC'D. BY REGISTRAR APR 17 1984		24b. REGISTRAR'S SIGNATURE John E. ...			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Julia R. CARTER				2b. HOUR 4:10A			
2. SEX Female		4. RACE Black B.		5. DATE OF BIRTH MONTH DAY YEAR April 27, 1909		6. AGE IN YEARS (LAST BIRTHDAY) 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Carter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Dorsey		13e. STREET ADDRESS 307 Plainview Ave., 21771			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-22-9511		17. INFORMANT ADDRESS Frances R. Dotson, Item 13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0000 DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) Secondary to endometrial ASCFB Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2/84 years.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/19/84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19		21f. LOCATION CITY OR TOWN COUNTY STATE 4/20/84			
22a. I certify that (X) (this hospital) attended the deceased from 4/19/84 to 4/20/84 and that in (my) XX opinion death occurred on the date and hour and from the causes stated above. (I) (X) did not view the body after death.							
22b. SIGNATURE MILANINIA M.D.				DEGREE		22c. DATE SIGNED 4/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MILANINIA M.D.				22e. ADDRESS 1500 Pennsylvania Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 23, 1984		23c. NAME OF CEMETERY OR CREMATORY Resthaven		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.	
24. FUNERAL DIRECTOR Olth L. Molesworth, P.A., Damascus, Md.				25a. DATE REC'D BY REGISTRAR APR 23 1984			
				25b. REGISTRAR'S SIGNATURE Julia R. Dotson			

BP 663

19

Resident
Veryland

Black
U.S.A.

April 25, 1968
X

Domestic

Veryland
William

Frederick
H.

Veryland
Carter

X

Josephine

305 Highland Ave.,
Veryland

810-22-9111
James H. Brown, Item 13

April 23, 1968
Frederick, Frederick, X
John I. Colverworth, P.A., Pasadena, Ca.
APR 23 1968
Frederick, Frederick

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 7 9 6

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME FIRST MIDDLE LAST
Maurice U. Clark
2a. DATE OF DEATH MONTH DAY YEAR
April 6, 1984
2b. HOUR
2:15 AM

3 SEX male 4 RACE white 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 6, 1892
6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.

10. CITY OR TOWN OF DEATH Hagerstown 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Coffman Nursing Home 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman 12b. KIND OF BUSINESS OR INDUSTRY Insurance

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE Dual Hwy. Towne House Apts. 21740

14. FATHER'S NAME FIRST MIDDLE LAST George Clark 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. W.W.I 192-18-6729 17. INFORMANT ADDRESS Nancy Boyer, Hagerstown, Md.

18 CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
4409
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
mos
Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 80 to 6 Apr. 19 84, that (I) (we) last saw the deceased alive on 4 Apr. 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.

22b. SIGNATURE DEGREE 22c. DATE SIGNED 4/6/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial 23b. DATE 4-9-84 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland

24 FUNERAL DIRECTOR MINNICH FUNERAL HOME 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
415 E. Wilson Blvd., Hagerstown, Md. APR 10 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



APR 10 1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon-copy pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____
DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emerson L Clopper			2a. DATE OF DEATH MONTH DAY YEAR 4 17 84		2b. HOUR 4:46 P.M.
3 SEX M	4 RACE W	5. DATE OF BIRTH MONTH DAY YEAR 9 11 05	6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ringgold, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler	12b. KIND OF BUSINESS OR INDUSTRY Machine Mfg.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST George Clopper			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie V. Keadle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 705-10-5967	17 INFORMANT ADDRESS Mrs. Susie L. Clopper, 340 S. Locust St. Hagerstown, Md. 21740		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes

10 years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

Recent Pneumonia - Recent Stroke

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE W.W. Lesh	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 4-17-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.W. Lesh		22e. ADDRESS 411 Division Ave Hagerstown, Md 21740	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 4-18-84	23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Wash. Co., Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. Boonsboro, Maryland		25a. DATE REC'D. BY REGISTRAR APR 23 1984	25b. REGISTRAR'S SIGNATURE

1944

Washington

Executive - Secretary

Director of the

Office

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

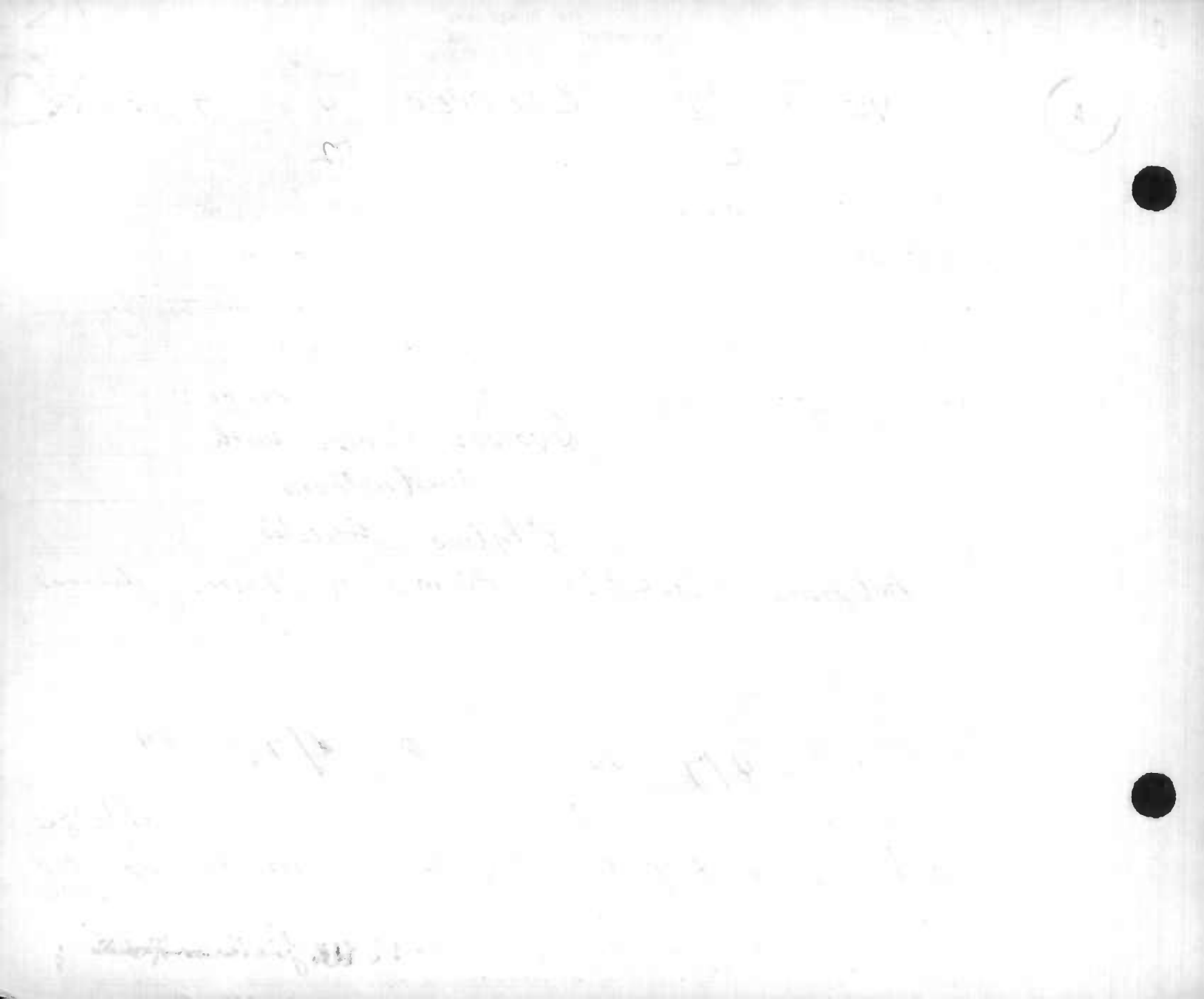
1. DECEASED NAME (TYPE OR PRINT) VIOLET IRENE CLOPPER		2a. DATE OF DEATH MONTH DAY YEAR 4 1 7 1984		2b. HOUR 11:59 AM
3. SEX F	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3/29/12		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Williamsport, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Daley Henson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Eta "Hose"		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Marion Halgash/ same as 13 e
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ovarian Cancer with 1830 DUE TO, OR AS A CONSEQUENCE OF metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF Chylous Ascites (c) Chylous Ascites				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Ankylosing Spondylitis, Anemia by Chronic disease				
19a. DATE OF OPERATION 4/7/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 4/7/84 to 4/7/84 , that (I) (we) last saw the deceased alive on 4/7/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Rolando V. Sarampote		DEGREE M.D.		22c. DATE SIGNED 4/7/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROLANDO V. SARAMPOTE		22e. ADDRESS 879 Commonwealth Ave. HAG. MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4/10/84	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash, Md.
24. FUNERAL DIRECTOR NAME Rest Haven Fuenral Chapel 1601 Pennsylvania Ave. Hagerstown, Md.				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the burial-transit permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR MARY DELLA COOPER				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST MARY Della Cooper				April 20 84 11:25 AM			
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 6, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70-69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagers town		13e. STREET ADDRESS / ZIP CODE 1053 Georgia Avenue 21740	
14. FATHER'S NAME FIRST MIDDLE LAST James L. Mills				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Della Mills			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-30-3745		17. INFORMANT ADDRESS James L. Cooper Route #1 Box 70 Williamsport, Md. 21795			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) suspect pulmonary embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) left static Breast cancer DUE TO, OR AS A CONSEQUENCE OF (c) To bone APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION April 17		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED relief pain, rhizotomy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1964 to Apr 20, 84 , that (I) (we) last saw the deceased alive on Apr 20, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. N. Weeks DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Apr 21 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.N. Weeks				22e. ADDRESS 580 North Hc Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-24-84		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., ADDRESS Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 25 1984 Julia Barker-Rodella			

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Mountain

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State of New York

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH	
			FIRST MIDDLE LAST MARY LOU COUDRIET		MONTH DAY YEAR 4-28-84	
3. SEX F			4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1939	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.	
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
13a. STATE Pennsylvania			13b. CITY OR TOWN Morrisdale		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waitress	
14. FATHER'S NAME George			15. MOTHER'S MAIDEN NAME Irene		12b. KIND OF BUSINESS OR INDUSTRY restaurant	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 200-20-5808		17. INFORMANT ADDRESS Mr. Lynn Coudriest, Morrisdale, PA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of breast</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>None</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (a) (this hospital) attended the deceased from <u>January</u> 19 <u>81</u> to <u>April 28</u> 19 <u>84</u> , that (b) (we) lost saw the deceased alive on <u>April 27</u> 19 <u>84</u> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) did (did not) view the body after death.						
22b. SIGNATURE <u>Richard E. Smith, M.D.</u>				22c. DATE SIGNED <u>4/28/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.				22e. ADDRESS 1708 Oak Hill Ave. Hagerstown, Md 21740		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 1, 1984		23c. NAME OF CEMETERY OR CREMATORY Keewaydin Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Keewaydin, Pennsylvania
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME				24b. ADDRESS 415 E. Wilson Blvd., Hagerstown, MD. 21740		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-proper. Pages 1 and 2 should be filed with the health officer within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charlotte Edna Craig				MONTH DAY YEAR HOUR 4 10 84 10:30AM			
3. SEX Female		4. RACE cau.		5. DATE OF BIRTH MONTH DAY YEAR 11 26 1899		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Welsh Run, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.	
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahrney Keedy Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) R.N.		12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Craig		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline V. Hacker		13e. STREET ADDRESS 105 E. Antietam St.		13f. STREET ADDRESS 45 North Carlisle Street	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-30-9546		17. INFORMANT Dr James H. Craig Jr.		17. INFORMANT ADDRESS Greencastle, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4280 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cystic heart failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WATTEED, MD		22e. ADDRESS 1600 Oak Hill Ave Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-13-84		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mercersburg, Franklin, Pa.	
24. FUNERAL DIRECTOR NAME A.K. Coffman		ADDRESS Funeral Home, Inc., Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR APR 16 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY V. DEANER			2a. DATE OF DEATH MONTH DAY YEAR April 8 1984			2b. HOUR 1A M			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Sept 02 1921		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lovettsville, Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTERN MARYLAND CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Brownsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Main St. 21715	
14. FATHER'S NAME FIRST MIDDLE LAST Elbert Mc Kinley Shoemaker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leila Maude Coffman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-20-8220		17. INFORMANT ADDRESS Peggy A. Lescalleet, Boonsboro, Maryland 21713					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) ANAPLASTIC METASTATIC BRAIN TUMOR DUE TO, OR AS A CONSEQUENCE OF (c) 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS OCT 1983	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from February 1 19 84 , to April 8 19 84 , that (X) (we) last saw the deceased alive on April 8 19 84 , and that in (my) (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Dr. H. Brown						DEGREE M.D.		22c. DATE SIGNED 4/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. Brown						22e. ADDRESS 1500 PENNSYLVANIA AVE, HAGERSTOWN, MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-11-84		23c. NAME OF CEMETERY OR CREMATORY Brownsville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brownsville, Wash. C. Md.		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr., Boonsboro, Md. 21713						25a. DATE RECEIVED BY REGISTRAR APR 11 1984			

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John A. Hove, Jr., Brownsville, Md. 2175

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 0 3

FOR
1 - STATE
REGISTRAR

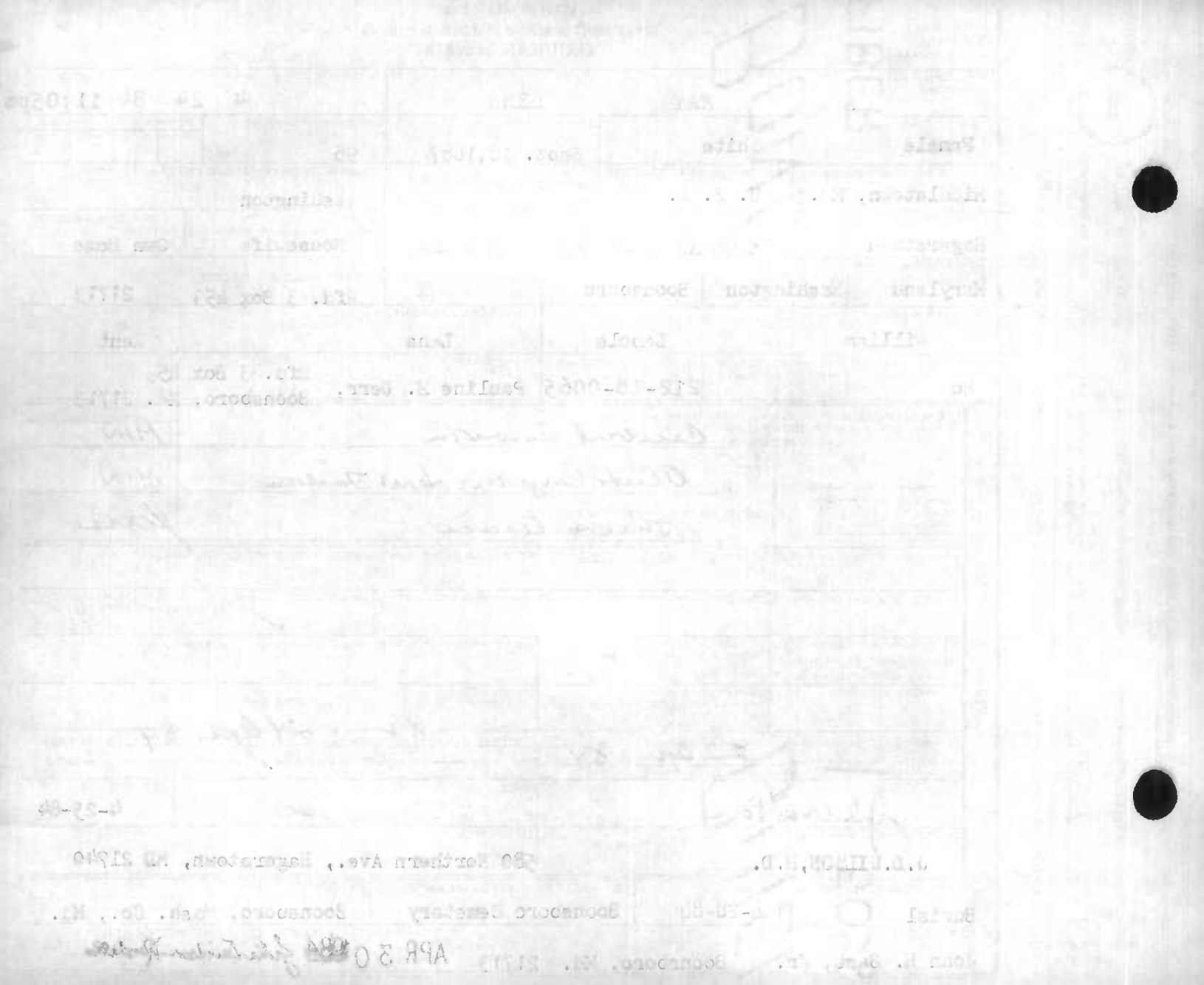
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADA MAY DERR			2a. DATE OF DEATH MONTH DAY YEAR 4 24 84			2b. HOUR 11:05pm		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Middletown, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COFFMAN HOME FOR THE AGING				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY Own Home								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE Rfd. 3 Box 453 21713								
14. FATHER'S NAME FIRST MIDDLE LAST William Lapole				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lana Rent				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-18-0065		17. INFORMANT ADDRESS Pauline M. Derr, Rfd. 3 Box 453 Boonsboro, Md. 21713				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN MIN Years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 22 Apr 84 , 19 84 , to 24 Apr 84 , 19 84 , that (I) (we) last saw the deceased alive on 22 Apr 84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE J. D. Wilson				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-25-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. WILSON, M.D.				22e. ADDRESS 580 Northern Ave., Hagerstown, MD 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-28-84		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co., Md.		
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.				ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR APR 30 1984		
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodella				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.



11-11-83

APR 30 11:02 PM

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 0 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OF NAME) FIRST <i>May</i> MIDDLE <i>B.</i> LAST <i>Ditto</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4-23-84</i>		2b. HOUR <i>7:50 p.m.</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 16, 1908</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington Co., MD.</i>	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Co. Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Health</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Pa.</i> 13b. COUNTY <i>Washington</i> 13c. CITY OR TOWN <i>Clear Spring</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>R.D. 3</i>	
14. FATHER'S NAME FIRST <i>James</i> MIDDLE <i>R.</i> LAST <i>Barron</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Florence</i> MIDDLE <i>Bitner</i> LAST <i>Bitner</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-38-1035</i>		17. INFORMANT ADDRESS <i>William O. Ditto R. #3, Clear Spring, Md. 21722</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4100

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>4-20-84</i> to <i>4-27-84</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>4-20-84</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <i>E. H. Lordzaba</i>		DEGREE		22c. DATE SIGNED <i>4-28-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. H. Lordzaba</i>		22e. ADDRESS <i>382 John Howard, Hagerstown, Md.</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>4/27/84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fairview</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Mercersburg Franklin Pa.</i>
24. FUNERAL DIRECTOR NAME <i>F. H. Linger</i>		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S NAME <i>APR 30 1984 John Linger</i>	

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DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

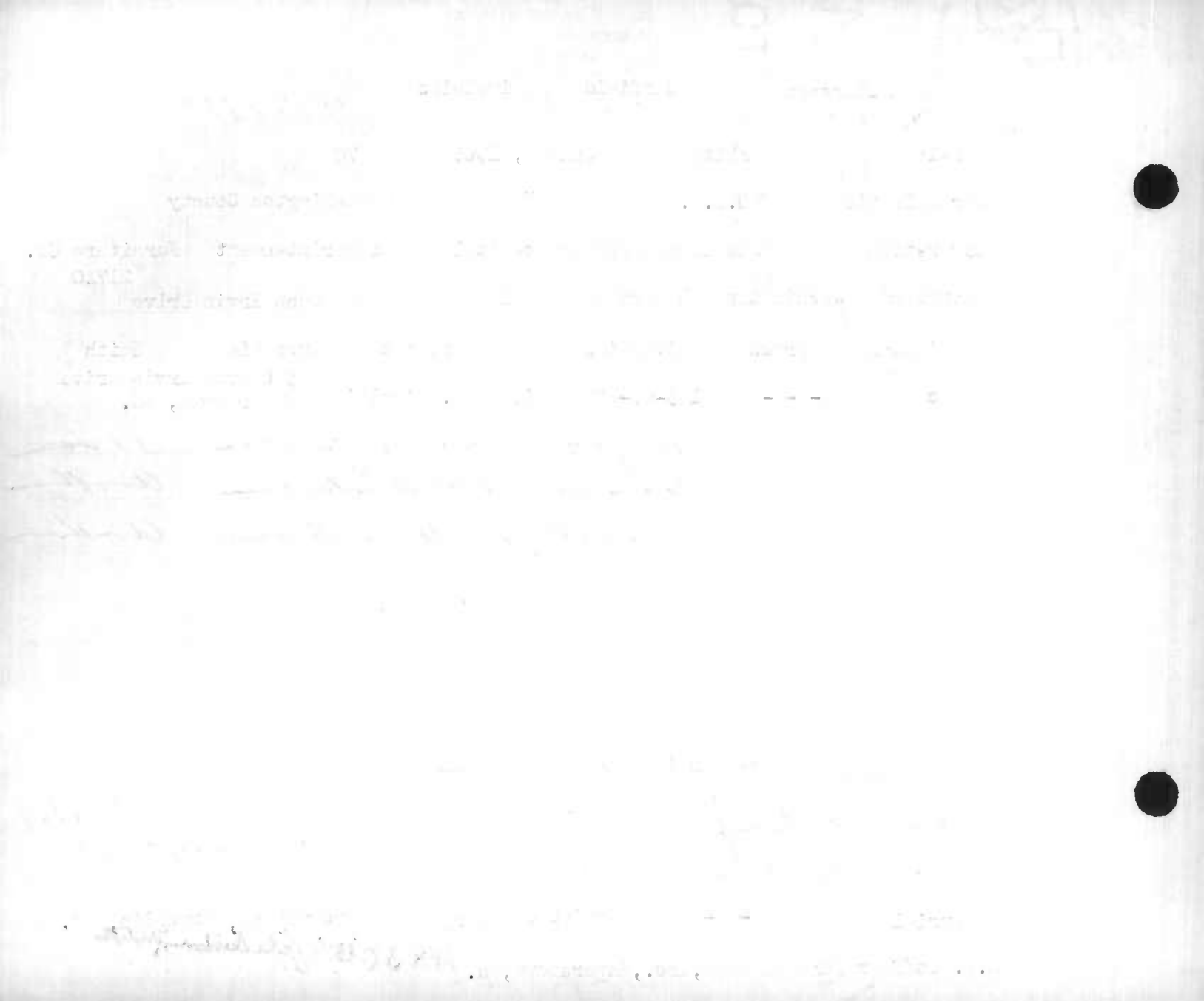
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) Clarence Garfield Divelbiss		2a. DATE OF DEATH MONTH DAY YEAR 4/24/84	
3. SEX Male			4. RACE White		2b. HOUR 1:15 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 78	
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
13a. STATE Maryland			13b. CITY OR TOWN Hagerstown		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
13c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) superintendent	
14. FATHER'S NAME FIRST MIDDLE LAST William Bruce Divelbiss			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Lucretia Smith		12b. KIND OF BUSINESS OR INDUSTRY Furniture Co.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 185-07-2322		13e. STREET ADDRESS / ZIP CODE 500 Dunn Irvin Drive 21740	
17. INFORMANT Lillie R. Divelbiss			ADDRESS 500 Dunn Irvin Drive Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs Arteriosclerosis Arteriosclerosis
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 4/23 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE L L Packard		DEGREE MD		22c. DATE SIGNED 4/24/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L L Packard		22e. ADDRESS 145 W Washington St Hagerstown Md 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-27-84		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mercersburg Franklin Md.
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.		ADDRESS Hagerstown, Md.		25. DATE RECEIVED BY REGISTRAR APR 30 1984		

APR 30 1984



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Judy Kathryn DORAN</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>4-10-84</i>				2b. HOUR MIN. <i>195</i>			
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>JAN. 11, 1917</i>				6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>67</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>HAGERSTOWN, MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>HELDON WASHINGTON CO.</i>			
10. CITY OR TOWN OF DEATH <i>WILLIAMSPORT</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WILLIAMSPORT NURSING HOME</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. STATE <i>MD.</i>				13b. COUNTY <i>WASH.</i>		13c. CITY OR TOWN <i>HAGERSTOWN</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>21740</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>CLARENCE BURKE BROWN</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNA "DITZLER"</i>				16. ADDRESS <i>DAMASCUS MD. 20872</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>234-05-1847</i>		17. INFORMANT <i>JUDY JOHNSON</i>				ADDRESS <i>25600 COLT RANE DR.</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:1539 IMMEDIATE CAUSE (a) *Carcinoma of Colon*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-22</i> 19 <i>84</i> , to <i>4-10</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>4-2</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John R. Melnick</i>				DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John R. Melnick</i>				22e. ADDRESS <i>16220 Frederick Rd. Gaithersburg, Md. 20760</i>			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>		23b. DATE <i>4/11/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SMITHSBURG CREMATORY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>SMITHSBURG, WASH MD</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>REST HAVEN FUNERAL CHAPEL 1601 PA. AVE. / HAGERSTOWN, MD.</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 12 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Papers may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transfer permit. Then please reinsert certificate in this folder. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) Mary Catherine Dutrow					MONTH DAY YEAR 04 10 84			
2. SEX Female					7b. HOUR 9:00a			
3. RACE White					M			
4. DATE OF BIRTH 08 15 95					6. AGE (IN YEARS LAST BIRTHDAY) 88			
5. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					IF UNDER 1 YEAR MONTHS DAYS			
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland					7b. CITIZEN OF WHAT COUNTRY? US			
7. CITY OR TOWN OF DEATH Hagerstown					9. BALTIMORE CITY OR COUNTY OF DEATH Washington			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H/W			
12b. KIND OF BUSINESS OR INDUSTRY					12c. STREET ADDRESS / ZIP CODE 8420 Rocky Springs Rd, 21701			
13a. STATE Md					13b. CITY OR TOWN Frederick			
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13d. STREET ADDRESS / ZIP CODE 8420 Rocky Springs Rd, 21701			
14. FATHER'S NAME Norman Julian					15. MOTHER'S MAIDEN NAME Mary E. Main			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 220-44-7537			
17. INFORMANT Mrs. Eloise Long					17. ADDRESS 8420 Rocky Springs Rd., Frederick, Maryland 21701			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: Acute Respiratory Failure								Hours
2765 IMMEDIATE CAUSE (a)								
DUE TO, OR AS A CONSEQUENCE OF Bronchopneumonia, right lung								Days
(b)								
DUE TO, OR AS A CONSEQUENCE OF Dehydration								Months
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a								
Decubiti, both heels and chronic brain syndrome								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
21g. I certify that (X) (this hospital) attended the deceased from 3/30 , 19 84 , to 4/10 , 19 84 , that X (we) last saw the deceased alive on 4/10 , 19 84 , and that in (my) (did) (we) (we) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (did) (we) (we) view the body after death.			22a. SIGNATURE Kyung S. Kim, M.D.			22b. ADDRESS 1500 Pennsylvania Ave, Hagerstown, Md 21740		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr 13, 1984			23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.			24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home			25a. DATE REC'D. BY REGISTRAR APR 13 1984		
25b. REGISTRAR'S SIGNATURE Julian Davidson Rodwell								



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST RALPH LEROY EBERSOLE SR.				APRIL 3, 1984			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 3 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DRIVER		12b. KIND OF BUSINESS OR INDUSTRY TRUCK	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY WASHINGTON 13c. CITY OR TOWN MAUGANSVILLE				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES JACOB EBERSOLE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA ELLEN MARTIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES NO OR UNKNOWN		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS BLANCHE M. EBERSOLE same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUDDEN DEATH</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 75 to 1-10 19 83, that (I) (we) last saw the deceased alive on 1-10 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OTTO ROZA MD				22e. ADDRESS 100606 15000 DRIVE 116682000 RD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/6/84		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN WASH MD.	
24. FUNERAL DIRECTOR REST HAVEN FUNERAL CHAPEL ADDRESS 1601 Pennsylvania Ave. Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 12 1984 [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH Y EGAN					2a. DATE OF DEATH MONTH 04 DAY 12 YEAR 84				2b. HOUR 6:20 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Aug. DAY 31 YEAR 1941		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1380 Marshall st. 21740		
14. FATHER'S NAME FIRST Jerome MIDDLE J. LAST Egan Sr.					15. MOTHER'S MAIDEN NAME FIRST Suzannah MIDDLE Fechtig LAST Ega Cushman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-624		17. INFORMANT Baltimore, Md. 21212 Jerome J. Egan Jr. 344 Brockmoor RD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5770 IMMEDIATE CAUSE (a) Respiratory Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wk	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Renal Failure 2 wk	
(c) Acute Pancreatitis 2 wk											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.											
19a. DATE OF OPERATION Peritoneal Dialysis			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Renal Failure			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M Douglas Becker						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-12-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M DOUGLAS BECKER						22e. ADDRESS 101 KING ST. HAGERSTOWN					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-14-84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE 				
24. FUNERAL DIRECTOR NAME Gerald N. Minnich						25a. DATE REC'D. BY REGISTRAR APR 19 1984					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1 - STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick Louis ERHARDT					2a DATE OF DEATH MONTH DAY YEAR April 29, 1984			2b HOUR 00 29A ^M		
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR March 10, 1903 ^{AR}		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE STATE OR FOREIGN COUNTRY New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10 CITY OR TOWN OF DEATH Williamsport		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center				12a USUAL OCCUPATION (THROW WORK FOR MOST OF WORKING LIFE) stock clerk		12b KIND OF BUSINESS OR INDUSTRY dept. store		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland					13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d STREET ADDRESS 903 Kenley Avenue 21740	
14 FATHER'S NAME FIRST MIDDLE LAST Frederick A Erhardt					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise E. Hein					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 061-05-4800		17 INFORMANT ADDRESS Mrs. Susan L. Gardenhour, Waynesboro, PA						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>4/28/84</u> 19 <u>83</u> , to <u>4/29/84</u> , that (I) (we) last saw the deceased alive on <u>4/28/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>[Signature]</u>				DEGREE MD				22c DATE SIGNED 4/30/84		
22d PHYSICIAN'S NAME (TYPE OR PRINT) 1916 W D St W				22e ADDRESS 1610 Oak Hill Ave. Hagerstown MD						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE May 3, 1984		23c NAME OF CEMETERY OR CREMATORY George Washington Mem.		23d LOCATION CITY OR TOWN COUNTY STATE Paramus New Jersey				
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME				25a DATE RECEIVED BY REGISTRAR MAY 02 1984 <u>[Signature]</u>						
415 E. Wilson Blvd., Hagerstown, Maryland 21740										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 1 8 1 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) LEWIS Hamilton EVERITT				2a. DATE OF DEATH MONTH 4 DAY 13 YEAR 1984		2b. HOUR 10:00 M A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 2 DAY 14 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Forman		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Big Pool		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST William MIDDLE Amos LAST Everitt		15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE Mae LAST Armstrong		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Don Bishop Big Spring Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-9 , 19 84 , to 4-12 , 19 84 , that (I) (we) last saw the deceased alive on 4-11 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles C. Spencer DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-12-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles C. Spencer				22e. ADDRESS 1198 Kenly Ave Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 16, 84		23c. NAME OF CEMETERY OR CREMATORY Shanktown		23d. LOCATION CITY OR TOWN COUNTY STATE Big Pool Wash. Md.	
24. FUNERAL DIRECTOR Thompson Funeral Home				25a. DATE REC'D BY REGISTRAR'S REGISTRATION SIGNATURE 18 1984			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE KNOWN OF DEATH					2b. HOUR						
WALTER KINGSON EXLINE										2b. DATE KNOWN OF DEATH					2b. HOUR						
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (IN YEARS)						
Male					WHITE					AUG. 18, 1932					51 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED					9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND					UNITED STATES					WIDOWED					WASHINGTON						
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION					12a. USUAL OCCUPATION					12b. KIND OF BUSINESS OR INDUSTRY						
HANCOCK					219 PENNSYLVANIA AVENUE					LAND MANAGEMENT					PA. SAND GLAS						
13a. STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?						
MARYLAND					WASHINGTON					HANCOCK					YES X NO						
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.						
WALTER H. EXLINE					MILDRED STEIN					YES					236-48-3668						
17. INFORMANT					18. CAUSE OF DEATH					19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						
BEVERLY M. EXLINE					SAME AS 13					4/10					Coronary heart disease (Code 410)						
19c. STREET ADDRESS					20. AUTOPSY?					21a. EXTERNAL CAUSE WAS					21b. TIME OF INJURY						
219 PENNA. AVE.					21750					UNDERLYING OR CONTRIBUTING CAUSE OF DEATH					HOUR A.M. MONTH DAY YEAR						
219 PENNA. AVE.					21750					21d. INJURY OCCURRED					21e. PLACE OF INJURY						
219 PENNA. AVE.					21750					WHILE AT WORK					STREET, FACTORY, FARM, ETC.)						
219 PENNA. AVE.					21750					21f. LOCATION					CITY OR TOWN						
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RECEIVED BY THE DIRECTOR OF THE
BUREAU OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.



APR 17 1964
U.S. ARMY

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR 1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Linton Fahrney						2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR April 19, 1984 7:45 PM			
3. SEX Female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 18 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10. CITY OR TOWN OR DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahrney-Keedy Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) practical nurse		12b. KIND OF BUSINESS OR INDUSTRY Health Care	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Washington Boonsboro						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 2 Box 91 21713	
14. FATHER'S NAME FIRST MIDDLE LAST John Zacharia Linton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Niceley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-30-9370		17. INFORMANT ADDRESS Mary Shipley 104 Devonshire Rd. Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>dance like arrest</u> 2639 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Abdul Latheef</u> DEGREE <u>MD</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/20/84	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL LATHEEF, MD				22e. ADDRESS 1600 Oak Hill Ave. Hager, MD 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-23-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE San Mar, Wash. Co., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS John H. Bast, Jr. Boonsboro, Md. 21713				25a. DATE REC'D. BY REGISTRAR APR 24 1984		25b. REGISTRAR'S SIGNATURE Chia Davidson, Director			

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May 1944

April 1944

March 1944

February 1944

January 1944

December 1943

November 1943

October 1943

September 1943

August 1943

July 1943

June 1943

May 1943

April 1943

March 1943

February 1943

January 1943

December 1942

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) MARY Marie FAULDER			2a DATE OF DEATH MONTH DAY YEAR April 20, 1984		2b HOUR M M
3 SEX female	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland			13b COUNTY Washington	13c CITY OR TOWN Hagerstown	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Clinton E. Shaffer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie M. Frye		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214-16-1303B		17 INFORMANT ADDRESS Ralph W. Faulder, Hagerstown, Md.	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) Coronary artery disease	years
	(c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diabetes, Hypertension

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 4-18 , 19 84 , to 4-20 , 19 84 , that (I) (we) last saw the deceased alive on 4-20 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE W S Hood	DEGREE W S Hood		22c. DATE SIGNED 4-21-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W S Hood		22e ADDRESS HAG.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Apr. 23, 1984	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland
24. FUNERAL DIRECTOR MINNICH FUNERAL HOME NAME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		25. DATE REC'D. BY REGISTRAR APR 25 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETURN PAGE 4 TO THE MEDICAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(OR A15 ME (5))
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert Ernest Flabbi						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 29 84		2b. HOUR M 2:20			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 12/15/52		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 29 84	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Thurmont		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Black's Mill Road 21788			
14. FATHER'S NAME FIRST MIDDLE LAST DANTE FLABBI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BLANCHE HELEN DONNELLY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-56-0726		17. INFORMANT ADDRESS Mrs. Robert Andrew 12814 Brice Road Thurmont, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio cerebral trauma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 5:15 P.M. 4 26 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/fixed object impact					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Frederick Freeway Frederick, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 4/30/84			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St. Balto.Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/2/84		23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Maryland	
24. FUNERAL DIRECTOR R. E. Dailey & Son, P.A.				25a. DATE REC'D. BY REGISTRAR MAY 4 1984				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rosa G Flook			2a. DATE OF DEATH MONTH 04 DAY 13 YEAR 84		2b. HOUR 7:30A M
3 SEX Female	4. RACE White	5. DATE OF BIRTH MONTH March DAY 27 YEAR 1899		6. AGE (IN YEARS, LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Myersville, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rfd. 2 Box 255A 21713	
14. FATHER'S NAME FIRST Michael MIDDLE LAST Hoffman		15. MOTHER'S MAIDEN NAME FIRST Minnie MIDDLE LAST Palmer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 213-74-4654		17. INFORMANT Carroll J. Flook, Myersville, Md. 21773	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction (c) Coronary Artery Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 10 hrs. 10 yrs.
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
Renal Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-12-84 to 4-13-84 that (II) we last saw the deceased alive on 4-13-84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
22b. SIGNATURE Charles F. Hess M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4-13-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Hess M.D.		22e. ADDRESS Smithsburg Md 21783	

23a. BURIAL, CREMATION, REMOVAL ISP Burial	23b. DATE 4-16-84	23c. NAME OF CEMETERY OR CREMATORY Grossnickle Cemetery	23d. LOCATION CITY OR TOWN Myersville, Frederick, Md. COUNTY STATE
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24. FUNERAL DIRECTOR NAME John H. Bast, Jr. ADDRESS Boonsboro, Maryland 21713	25a. DATE REC'D. BY REGISTRAR APR 17 1984	25b. REGISTRAR'S SIGNATURE [Signature]
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 1 7

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert Charles Frick			2a. DATE OF DEATH MONTH DAY YEAR 4 4 84			2b. HOUR 125 AM				
3. SEX Male		4. RACE Cal.		5. DATE OF BIRTH MONTH DAY YEAR Jan. 12, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) drafting		12b. KIND OF BUSINESS OR INDUSTRY aircraft		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 407 Sherwood Dr. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Frick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Dintinger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-14-2384		17. INFORMANT ADDRESS George Frick, Hagerstown, Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY FAILUREAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**4960**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **LOBAR PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CHRONIC OBSTRUCTIVE Pulmonary Disease**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

DIABETES MELLITUS & ATHEROSCLEROTIC HEART DISEASE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 3, 1984 to April 4, 1984 , that (I) (we) last saw the deceased alive on April 3, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dino J Delaportas M.D.				DEGREE M.D.		22c. DATE SIGNED April 4, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DINO J DELAPORTAS M.D.				22e. ADDRESS 703 Oak Hill Ave, Hagerstown, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR APR 6 1984		25b. REGISTRAR'S SIGNATURE Lia Davidson-Rendell	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST Goldie L. Gloss		April 24 1984		12:10 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR Jan. 5, 1920	64 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Keedysville, Md.	U. S. A.		Washington MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Washington County Hospital		Housewife	Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland		Washington	Hagerstown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	11 W. Baltimore St. 21740
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Otis R. Long		Esther Rowland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS			
No	213-18-8321	Mrs. Sarah E. Jones, 13 Della Lane Boonsboro, Md. 21713			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ductal Cell Carcinoma of Breast with</u> <u>1749</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from _____, 19 <u>85</u> , to <u>4-24</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>4-24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <u>Charles P. Spencer</u> DEGREE <u>MD.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4-25-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Charles P. Spencer		1198 Kenly Ave Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	4-27-84	Boonsboro Cemetery	Boonsboro, Wash. Co., Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
John H. Bast, Jr.		Boonsboro, Md. 21713		APR 27 1984 <u>John H. Bast, Jr.</u>	

BP

CAUSE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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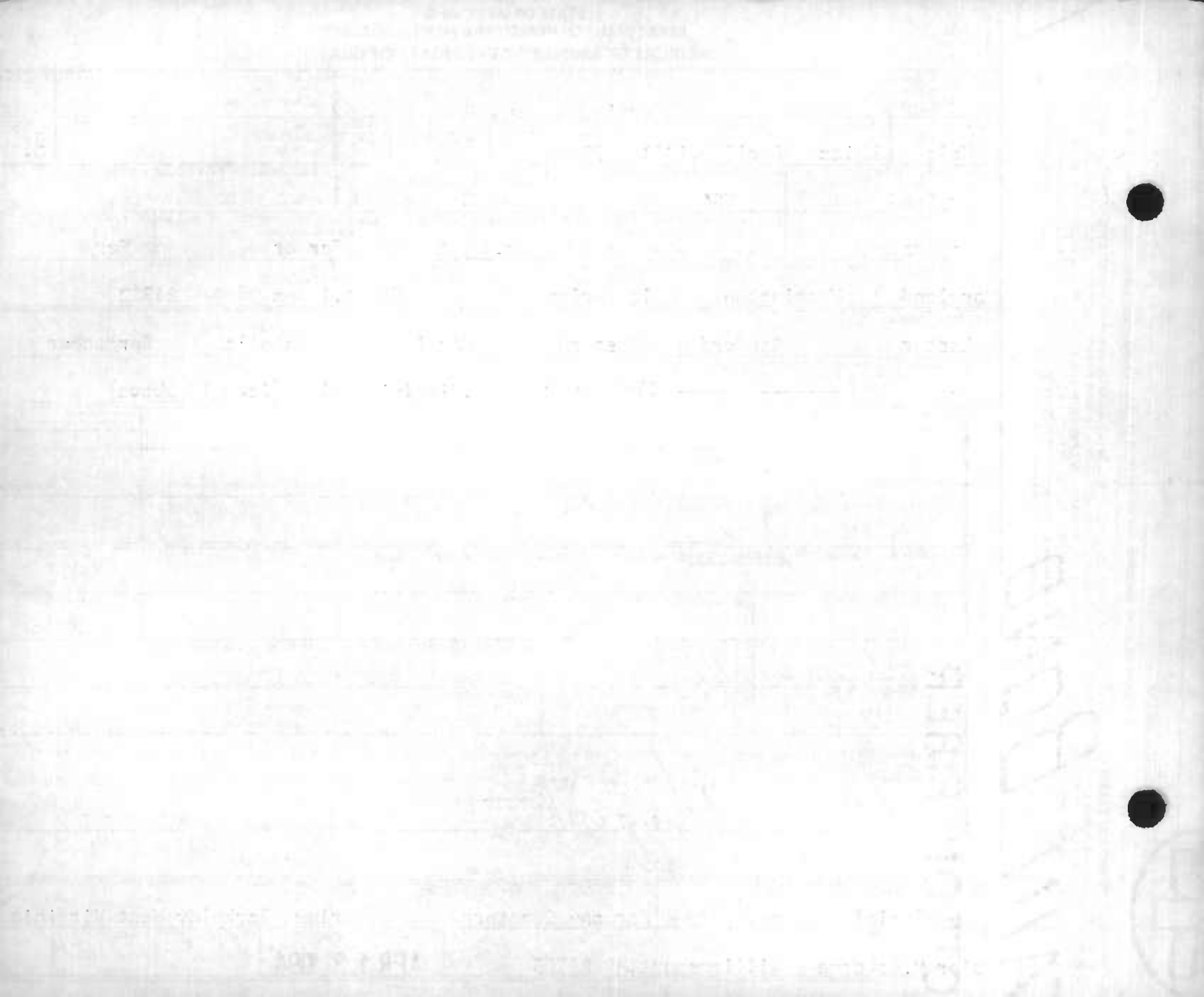
[illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Charles Martin Gossard							2a. DATE KNOWN OF DEATH MONTH XX DAY 4-5 YEAR 1984		2b. HOUR 9:10		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH April DAY 8 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7c. DATE PRONOUNCED DEAD MONTH 4-5 DAY 1984		7d. HOUR 9:10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD		
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 40 east of Conococheague bridge				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Big Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1 Box 98		21722	
14. FATHER'S NAME FIRST Lester MIDDLE Sanford LAST Gossard			15. MOTHER'S MAIDEN NAME FIRST Margie MIDDLE Estella LAST Spreacher								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 214-36-0051			17. INFORMANT ADDRESS S. Virginia Leigh (item 13 above)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt Trauma to Chest 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:35xx 4-5 1984				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto impact			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET Rt. 40 east of Conococheague bridge CITY OR TOWN Wash. Co. COUNTY Md. STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth				TITLE (SPECIFY) Assistant				DATE SIGNED 4-6-84			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Apr. 9, 1984		23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery			23d. LOCATION CITY OR TOWN Marlowe Berkeley West Virginia COUNTY STATE		
24. FUNERAL DIRECTOR NAME Major M. Osborne ADDRESS Williamsport, MD 21795						25a. DATE REC'D. BY REGISTRAR APR 13 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 2 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KATHRYN IOLA GRAHAM			2a. DATE OF DEATH MONTH DAY YEAR April 5, 1984			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Coffman Home for the Aging				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	
12b. KIND OF BUSINESS OR INDUSTRY Dry Cleaners		13a. STREET ADDRESS / ZIP CODE 12 Walnut Street 21740					
13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
14. FATHER'S NAME FIRST MIDDLE LAST John H. Kuhn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Perrell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-10-1101		17. INFORMANT ADDRESS Amantha E. Conway Box 51 Rohrersville, Md. 21779			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

4254 IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Min.

Hours

Years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Diabetes Mellitus

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 83 , 19 84 , to 5 Apr. , 19 84 , that (I) was last saw the deceased alive on 4 April , 19 84 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (and not) view the body after death.							
22b. SIGNATURE J. D. Wilson, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. Wilson				22e. ADDRESS Northern Avenue, Hagerstown, Md. 21740			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-7-84		23c. NAME OF CEMETERY OR CREMATORY Little Rose Hill Cemetery Clear Spring, Washington, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.,				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 10 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 of this certificate should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP



NAME		ADDRESS		CITY		STATE	
J. L. Wilson		1234 Main Street		Springfield		Illinois	
John Doe		456 Elm Street		Chicago		Illinois	
Mary Smith		789 Oak Avenue		New York		New York	
Robert Johnson		101 Pine Street		Los Angeles		California	
Elizabeth Brown		202 Cedar Lane		Boston		Massachusetts	
James White		303 Birch Road		San Francisco		California	
Margaret Green		404 Walnut Street		Philadelphia		Pennsylvania	
William Black		505 Spruce Avenue		Seattle		Washington	
Anna Taylor		606 Hickory Lane		Portland		Oregon	
Charles Hall		707 Ash Street		Denver		Colorado	
Helen King		808 Sycamore Avenue		San Diego		California	
George Lee		909 Magnolia Road		Austin		Texas	
Frances Miller		1010 Poplar Street		Nashville		Tennessee	
Edward Davis		1111 Chestnut Lane		Indianapolis		Indiana	
Lillian Moore		1212 Elm Avenue		Columbus		Ohio	
Frank Wilson		1313 Oak Street		Milwaukee		Wisconsin	
Grace Taylor		1414 Pine Road		Minneapolis		Minnesota	
Harold King		1515 Cedar Lane		St. Paul		Minnesota	
Irene Lee		1616 Birch Street		Des Moines		Iowa	
Jack Miller		1717 Walnut Avenue		Omaha		Nebraska	
Katherine Hall		1818 Spruce Road		Lincoln		Nebraska	
Leo King		1919 Hickory Lane		Kansas City		Missouri	
Mildred Lee		2020 Ash Street		St. Louis		Missouri	
Nathan Miller		2121 Sycamore Avenue		Cincinnati		Ohio	
Olivia King		2222 Magnolia Road		Cleveland		Ohio	
Oscar Lee		2323 Poplar Street		Detroit		Michigan	
Pamela Miller		2424 Chestnut Lane		Ann Arbor		Michigan	
Quinn Hall		2525 Elm Avenue		Flint		Michigan	
Ruth King		2626 Oak Street		Lansing		Michigan	
Samuel Lee		2727 Pine Road		Warren		Michigan	
Tina Miller		2828 Cedar Lane		Livonia		Michigan	
Ulysses King		2929 Birch Street		Farmington Hills		Michigan	
Verna Lee		3030 Walnut Avenue		Westland		Michigan	
Walter Miller		3131 Spruce Road		Dearborn		Michigan	
Xenia King		3232 Hickory Lane		Livonia		Michigan	
Yvonne Lee		3333 Ash Street		Farmington Hills		Michigan	
Zoe Miller		3434 Sycamore Avenue		Westland		Michigan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>HELEN Moberly GROSS</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 3 84</i>		2b. HOUR <i>8:37 AM</i>	
3. SEX <i>FEMALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>8 17 04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 74 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.		
10. CITY OR TOWN OF DEATH <i>HAGERSTOWN</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>AVAILON MANOR</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SECRETARY</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>MARYLAND</i>		13b. COUNTY <i>WASH.</i>	13c. CITY OR TOWN <i>HAGERSTOWN</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>631 Preston Rd. 21740</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>LEWIS A MOBERLY</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>BESSIE CRAMER</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>214-09-8212</i>		17. INFORMANT ADDRESS <i>Louis Geisbert 3618 Ester Place Baltimore Md. 21224</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>4409</i> IMMEDIATE CAUSE (a) <i>Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>Years</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <i>Dementia</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>W. L. ...</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>4/5/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>REST HAVEN CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>HAGERSTOWN WASHINGTON MD.</i>
24. FUNERAL DIRECTOR <i>REST HAVEN FUNERAL CHAPEL, INC.</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 6 1984</i>		
1601 Pennsylvania Ave. Hagerstown, Md				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert Lee HAHN			2a. DATE OF DEATH MONTH DAY YEAR April 1, 1984		2b. HOUR 10:00 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 16, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brownsville, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Keedysville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rfd. 1 Box 268		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Construction
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Keedysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rfd. 1 Box 268 21756
14. FATHER'S NAME FIRST Charles MIDDLE E. LAST Hahn		15. MOTHER'S MAIDEN NAME FIRST Stella MIDDLE LAST Baker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-26-1433		17. INFORMANT Robert Dillon, 14206 Lake View Dr. Gainesville, Va. 22065	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest, probable</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unwitnessed at home
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCVD, CHF</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7</u> 19 <u>81</u> , to <u>3</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>4/30</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (did not) view the body after death.					
22b. SIGNATURE <u>R. L. Hughes</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. L. Hughes		22e. ADDRESS 100 Geeting Ln Keedysville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-4-84	23c. NAME OF CEMETERY OR CREMATORY Brownsville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brownsville, Wash. C. Md.
24. FUNERAL DIRECTOR NAME John H. Bast, Jr. ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR APR 4 1984		25b. REGISTRAR'S SIGNATURE John Davidson	

BP

1000

April 1, 1908

WEEK

Day

Month

File

Title

May 12, 1908

Location

U. S. A.

Brownsville, Tex.

Construction

Notes

Box 100

Brownsville

1908

Box 100

1

Brownsville

Washington

Maryland

Notes

Notes

Notes

Notes

Notes taken from...

Notes taken from...

Notes taken from...

Notes taken from...



Brownsville Cemetery, Brownsville, Tex.

Brownsville Cemetery, Brownsville, Tex.

1908

1908

John H. Galt, Jr., Brownsville, Tex.

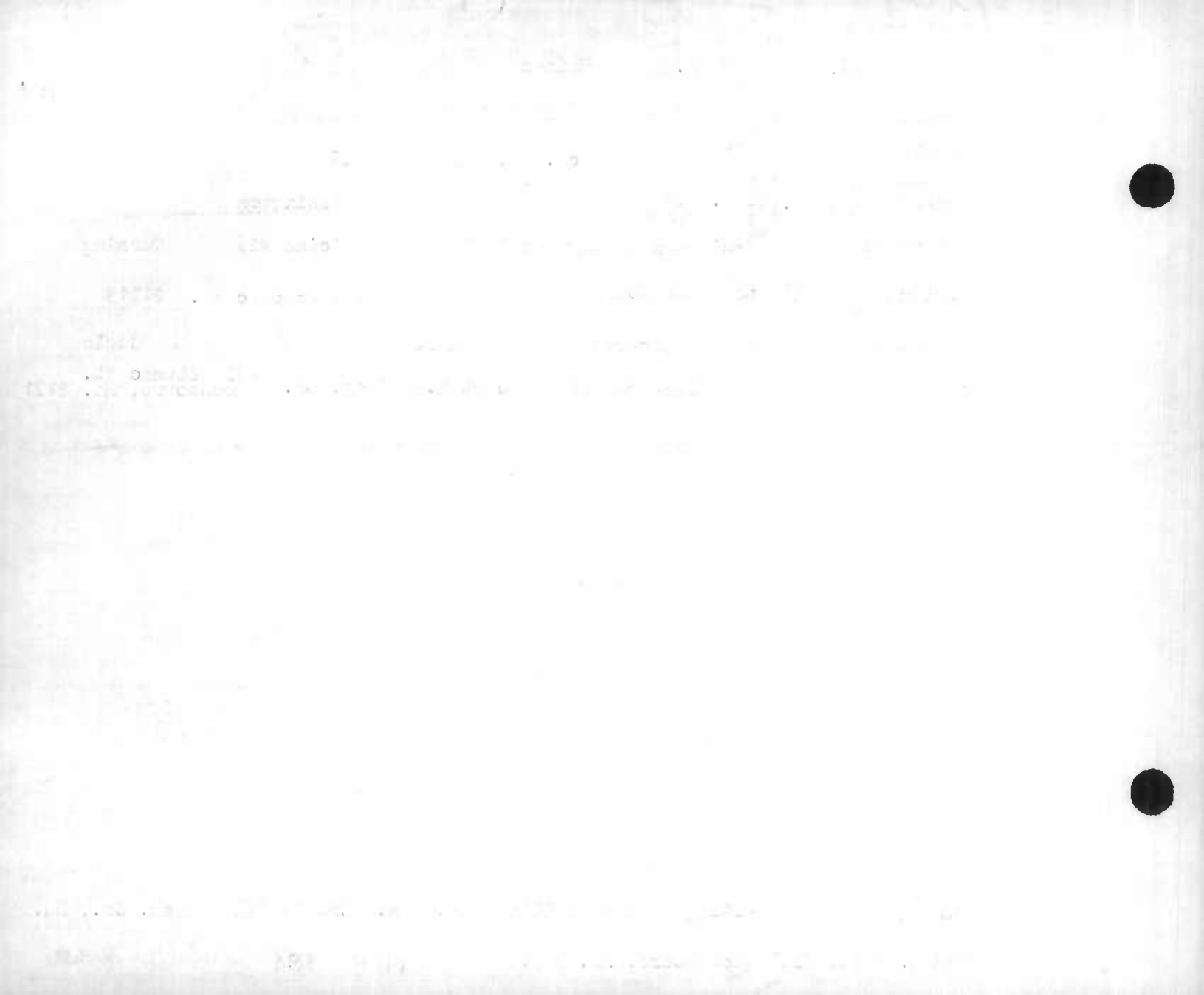
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR		Naneva L. Haines		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Naneva L Haines		2a. DATE OF DEATH MONTH DAY YEAR 4 2 84	
3 SEX Female		4 RACE White		2b. HOUR 6 45 P M	
5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Stephen City, Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Stephen City, Va.		10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medicine Aid		12b. KIND OF BUSINESS OR INDUSTRY Nursing		13. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro	
14. FATHER'S NAME FIRST MIDDLE LAST Ermon Lee Breeden		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Cogle		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
17. INFORMANT Robert M. Haines, Sr.		18. SOCIAL SECURITY NO. 234- 60-3257		19. ADDRESS 122 Potomac St. Boonsboro, Md. 21713	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4/12 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Frederic A. Kass		22c. DATE SIGNED 4/13/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-5-84		23c. NAME OF CEMETERY OR CREMATORY Brownsville Hgts. Cem.	
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.		25. DATE REC'D. BY REGISTRAR APR 6 1984		26. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JAMES DARYL HALL										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> APR. 21 1984	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 3, 1957		6. AGE (IN YEARS) LAST BIRTHDAY 26 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7b. DATE PRONOUNCED DEAD MONTH DAY YEAR APRIL 21 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON			10. HOUR 1:40 P.M.		
10. CITY OR TOWN OF DEATH Fairplay		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1 Box# 94				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Tech.		12b. KIND OF BUSINESS OR INDUSTRY Elect. Lab.		10. HOUR 2:40 P.M.	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Fairplay		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1 Box# 94		13f. ZIP CODE 21733	
14. FATHER'S NAME FIRST MIDDLE LAST James Hobart Hall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Jean Crawford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) unk.		17. INFORMANT ADDRESS Virginia M. Hall (item 13 above)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) N-933 - Aspiration of Gastric Contents DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 1:00 P.M. APR. 21 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) APPARENT ASPIRATION GASTRIC CONTENTS					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET ROUTE #1,		CITY OR TOWN FAIRPLAY, WASHINGTON,		STATE MD.	
22a. I certify that I took charge of the remains described above, held on death resulted from _____ Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Edward W. Ditto III				TITLE (SPECIFY) DEPUTY				MEDICAL EXAMINER 217 WEST WASHINGTON STREET		DATE SIGNED APR. 23, 1984	
EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.				ADDRESS HAGERSTOWN, MARYLAND 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Apr. 24, 1984		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Tilghmanton Washington Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Major M. Osborne Williamsport, MD 21795						25a. DATE REC'D. BY REGISTRAR APR 25 1984		25b. REGISTRAR'S SIGNATURE J. A. Dwyer			

• • • • •

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 2 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Richard B. Harbaugh</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 24 84</i>			2b. HOUR <i>8:53pm</i>				
3. SEX <i>M</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 31, 1927</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>56</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington Co.</i> MD.				
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Co. Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Machine Inspector</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Refrigeration Co.</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Cascade</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Box 83 21714</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Harbaugh</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mabel E. Cline</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				
16b. SOCIAL SECURITY NO. <i>212-24-7177</i>			17. INFORMANT ADDRESS <i>Mrs. Lori Warner 619 Foulger St. 17268</i>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <i>5722</i> IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septic Shock</i>		<i>48 hours</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hepatic Coma</i>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
Cirrhosis secondary to chronic alcoholism & malnutrition

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/22 19 84</i> to <i>4/24 19 84</i> , that (I) (we) lost saw the deceased alive on <i>4/24 19 84</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
27b. SIGNATURE <i>R. L. Kuyler MD</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED <i>4/24/84</i>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. L. Kuyler MD</i>		27e. ADDRESS <i>100 Geeting Ln Keedysville, Md</i>					

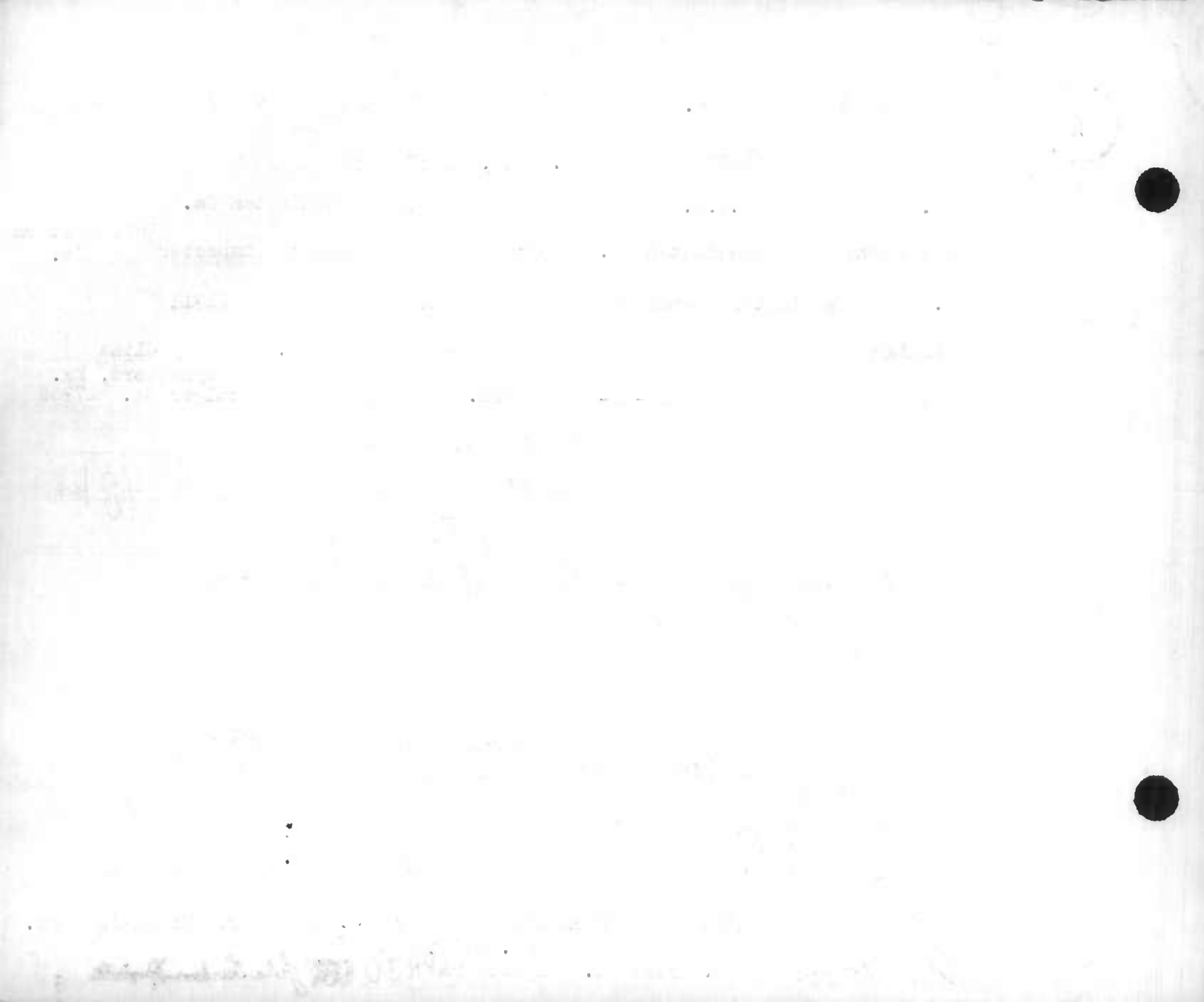
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/27/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Waynesboro Franklin Pa.</i>	
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24. FUNERAL DIRECTOR NAME <i>John J. Green</i>		ADDRESS <i>50 S. Broad St. Waynesboro Pa. 17268</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 30 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Green</i>	
--	--	--	--	---	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mable Margarette Harper										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 3/15/84		2b. HOUR P M 3:00	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 23, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4/7/84		2d. HOUR P M P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County			
10. CITY OR TOWN OF DEATH Sharpsburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 100 W. Main Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler		12b. KIND OF BUSINESS OR INDUSTRY Aircraft			
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 100 W. Main St. 21782			
14. FATHER'S NAME FIRST MIDDLE LAST Issac Garfield Holmes						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Alice Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-16-1861		17. INFORMANT Chester Miller				ADDRESS Rt. 1 Bx. 132 Falling Waters.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Alcoholism; history													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE [Signature]						TITLE (SPECIFY) M.D.				MEDICAL EXAMINER [Signature]			
EXAMINER'S NAME (TYPE OR PRINT) Major M. Osborne Williams						ADDRESS MD 21795				DATE SIGNED APR 13 1984			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Apr. 9, 1984		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington Maryland			
24. FUNERAL DIRECTOR NAME Major M. Osborne Williams						ADDRESS MD 21795		25a. DATE REC'D. BY REGISTRAR APR 13 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

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RECEIVED BY THE DIRECTOR OF THE
BUREAU OF THE ARMY
WASHINGTON, D. C.

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1917

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 2 7

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Bessie Marie Harris</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>Apr. 24, 1984</u>			2b. HOUR <u>3 13</u> M		
3. SEX <u>F</u>	4. RACE <u>white</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>9 3 1899</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS			7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN) <u>Pennsylvania</u>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.			10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>School Teacher</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		

13a. STATE <u>Maryland</u>			13b. COUNTY <u>Washington</u>			13c. CITY OR TOWN <u>Hagerstown</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>McClellan M. Woodring</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Grace D. Butterworth</u>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		
17. INFORMANT NAME ADDRESS <u>Darrell E. Harris Box 73</u>			18. SOCIAL SECURITY NO. <u>213745901</u>			19. STREET ADDRESS / ZIP CODE <u>11 W. Baltimore St. 21740</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>4292</u> IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Moments</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular</u>		<u>15-20 yrs</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease</u>			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (myself) attended the deceased from Jan 28, 1984, to Apr 24, 1984, that (I) (we) last saw the deceased alive on Apr 24, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Edward W. Dittus, MD</u>		DEGREE		22c. DATE SIGNED <u>Apr 24, 1984</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edward W. Dittus, MD</u>		22e. ADDRESS <u>217 W. Washington St.</u> <u>Hagerstown, Md 21740</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Apr 27, 84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lafayette Memorial Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brier Hill Fayette Pa</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>MINNICH FUNERAL HOME</u> <u>415 E. Wilson Blvd., Hagerstown, Md. 21740</u>				25a. DATE REC'D. BY REGISTRAR <u>APR 30 1984</u>			
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1-3 are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 799-1234.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 3 2 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Teresa May Hawkins			2a. DATE OF DEATH MONTH DAY YEAR April 8, 1984		2b. HOUR M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 17, 1953		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lunch Aid		12b. KIND OF BUSINESS OR INDUSTRY School
13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Robert F. Davis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances M. Strausbaugh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- -- --		17. INFORMANT ADDRESS 267 South Potomac St Bradford E. Hawkins Sr. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> 4301 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MASSIVE INTRACEREBRAL HEMATOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GIANT CEREBRAL ANEURYSM.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 to:					
19a. DATE OF OPERATION 4-4-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral Aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jack P. Carey M.D.				22c. DATE SIGNED	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Jack P. Carey, M.D.				22c. ADDRESS 1190 Mt Actna Rd Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-10-84		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md.		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME ADDRESS A.K. Coffman Funeral Home, Inc., Hagerstown, Md.					

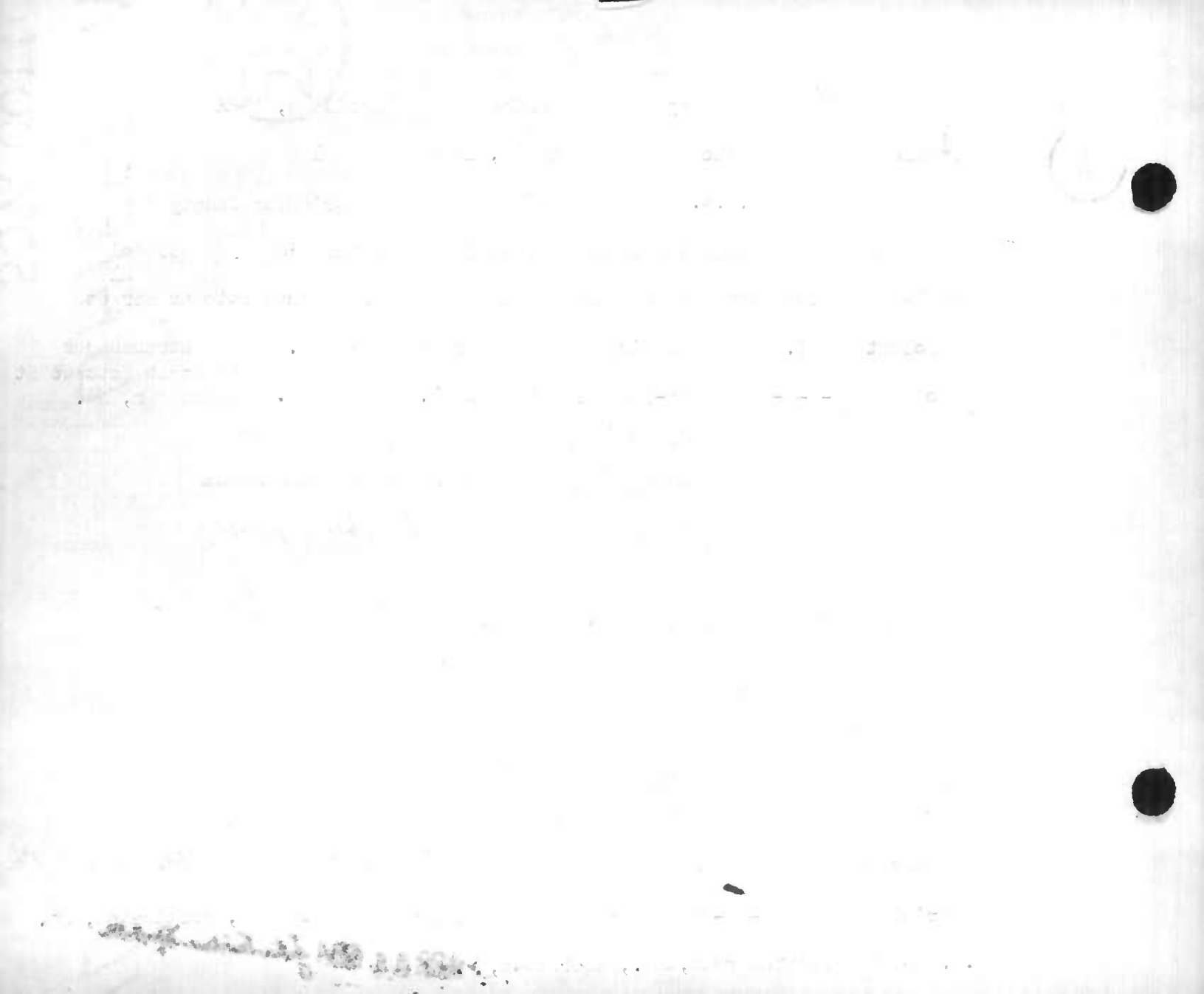
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE ESTI- MATED		2c. DATE PRONOUNCED DEAD		2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
Ralph Cossetta Henzsley		Male		Black		May 20 1908		75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Va.		U.S.A.				Washington		Hagerstown	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY	
54 Murph Avenue		Schoolteacher				Md.		Washington	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		54 Murph Avenue 21740		William C. Henzsley		Catherine Corrine Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		230-01-8230		Gwendolyn Henzsley		4292 Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF		4292	
				Cumberland, Md.		(b) _____ DUE TO, OR AS A CONSEQUENCE OF			
						(c) _____ DUE TO, OR AS A CONSEQUENCE OF			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
Alvin W. Davis MD		1610 Oak Hill Ave Hagerstown MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		4-10-84		Rose Hill Cem.		Hagerstown Wash. Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE OF RECORD FILED					
Dennis L. Davis		Smithburg, Md.		APR 11 1984					

1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) SAMUEL Enoch HOLMES			2a. DATE OF DEATH MONTH DAY YEAR 4-17-84		2b. HOUR 3:20 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 5-11-1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John W. Holmes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betsy Ellen Daugherty		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-10-3765		17. INFORMANT Rayetta Bowers (item 13 above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4960 cardiac arrest IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (c) chronic obstructive pulmonary disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Abdul Wateed		DEGREE MD		22c. DATE SIGNED 4/20/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WATEED, MD		22e. ADDRESS 1600 OAK HILL AVE. HAG. MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/20/1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Washington Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Major M. Osborne Wmspt. MD			
25a. DATE REC'D. BY REGISTRAR APR 25 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson			

BP _____

A

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE EHA HOSE			2a. DATE OF DEATH MONTH DAY YEAR 4-12-84		2b. HOUR 1:53pm	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 16, 1893		
6. AGE (IN YEARS LAST BIRTHDAY) 91		8. YRS. 91		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AVALON MANOR		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STREET ADDRESS Main St.		
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Clearspring		
14. FATHER'S NAME FIRST MIDDLE LAST George Hose		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 220-30-9947		17. INFORMANT ADDRESS Mrs. Patsy McKee Clearspring Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, rt lung & pleural effusion DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Arteriosclerotic Heart Disease Diabetes Mellitus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from May 19 80 to 12 April 19 84 , that (I) (we) last saw the deceased alive on 12 April 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE [Signature]		DEGREE MD		22c. DATE SIGNED 13 April 84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. N. Fender		22e. ADDRESS 138 E Antietam St. Hagerstown, Md 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 14, 84		23c. NAME OF CEMETERY OR CREMATORY St. Pauls		
23d. LOCATION CITY OR TOWN COUNTY STATE Clearspring Wash. Md		24. FUNERAL DIRECTOR Thompson Funeral Home Clearspring Md				
25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Julia Davidson Rodella				

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

1-10-11-12

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April 10, 1901

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 3 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SEAN			2a. DATE OF DEATH MONTH DAY YEAR 4-27-84			2b. HOUR 12 ⁵⁸ A M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 03/18/21		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Latrobe, Pa.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASH. COUNTY HOSPITAL			9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.		
13a. STATE MD			13b. COUNTY WASH			13c. CITY OR TOWN HAGERSTOWN		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE WHEELER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEAN "QUINN"			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY Home			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 381 AVALON AVE 21740		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-30-9388			17. INFORMANT Evelyn Smith Rt #2. Cove Rd. Clear Spring, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest -
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Coronary Artery Disease, Diabetic Mellitus

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> , 19 <u>84</u> , to <u>4/27</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4/26</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>S. MAJID</u>				DEGREE M.D.		27a. DATE SIGNED 4/27/84	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) S. MAJID M.D.				22e. ADDRESS Washington County Hosp Emergency Room		27b. REGISTRAR'S SIGNATURE Julia Davidson-Rodolfo	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/30/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Rest Haven Funeral Chapel, Inc. 1601 Pa. Ave. / Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR MAY 1 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Physicians be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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See Certificate Number 84-34939

Lola Catherine Humbelsine - Wash.Co. 4/21/84



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 5 AND 6 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
TIMOTHY L. HUNTER								4-28-84		4		28		84		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	8/7/67		67		16				5-8-84		5		8		19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Balto.		USA		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Washington County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Little Orleans		Potomac River		Student													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Balto.		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1216 Harwood Ave								21239	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
James		Sandra		No		N/A		Sandra Hunter		1216 Harwood Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
9109		Drowning															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		subject found in water											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		Potomac River		Little Orleans		Maryland							
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input type="checkbox"/>		Accident <input checked="" type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		5-9-84											
Margarita A. Korell, M.D.		Assistant		M.D.													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		5/12/84		Mt. Calvary Cemetery		Balto						Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
William C. Brown		1206 W. North Ave.		Balt., Md		MAY 15 1984											

6

W. H. H. H.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 3 3 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ADA (Sophia) HUTZELL			2a. DATE OF DEATH MONTH DAY YEAR Apr 3 1984			2b. HOUR 12:02 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 14, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Locust Grove, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Own Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Rfd. 3 Box 414 21713							
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Poffenberger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sophia Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-24-5616		17. INFORMANT ADDRESS Rfd. 1 Mrs. Margaret G. Grimm, Keedysville, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Arteriosclerotic Heart Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Hours

Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

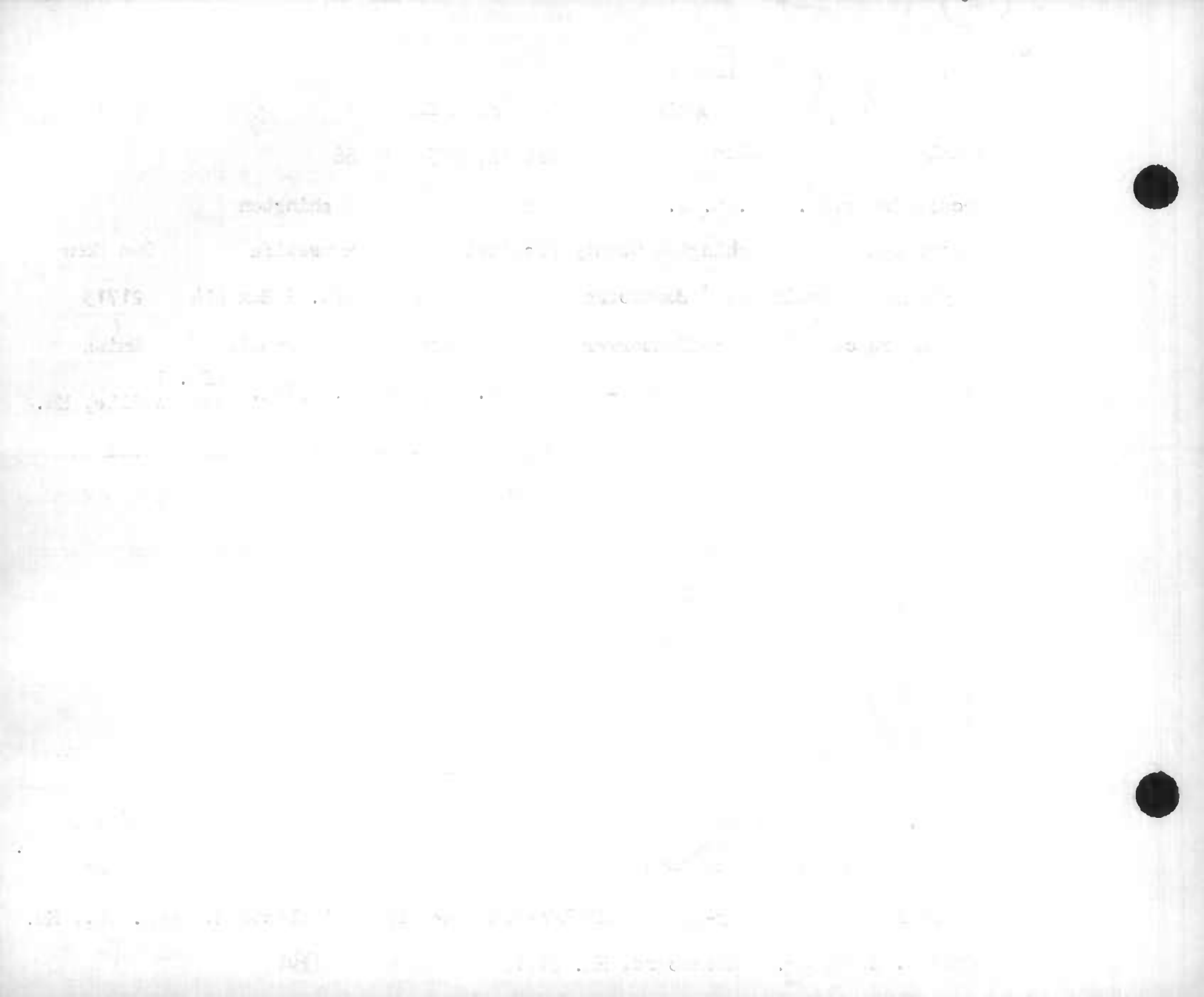
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 4-2 , 19 84 , to 4-3 , 19 84 , that (I) (we) lost saw the deceased alive on 4-2 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Charles C. Spenser MD				22c. DEGREE MD		22e. DATE SIGNED 4-3-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES C. SPENSER				22f. ADDRESS 1198 Kenly Ave Hagerstown			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-5-84		23c. NAME OF CEMETERY OR CREMATORY Zittlestown Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Zittlestown, Wash. Co., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS John H. Bast, Jr. Boonsboro, Md. 21713				25a. DATE REC'D. BY REGISTRAR APR 6 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at _____

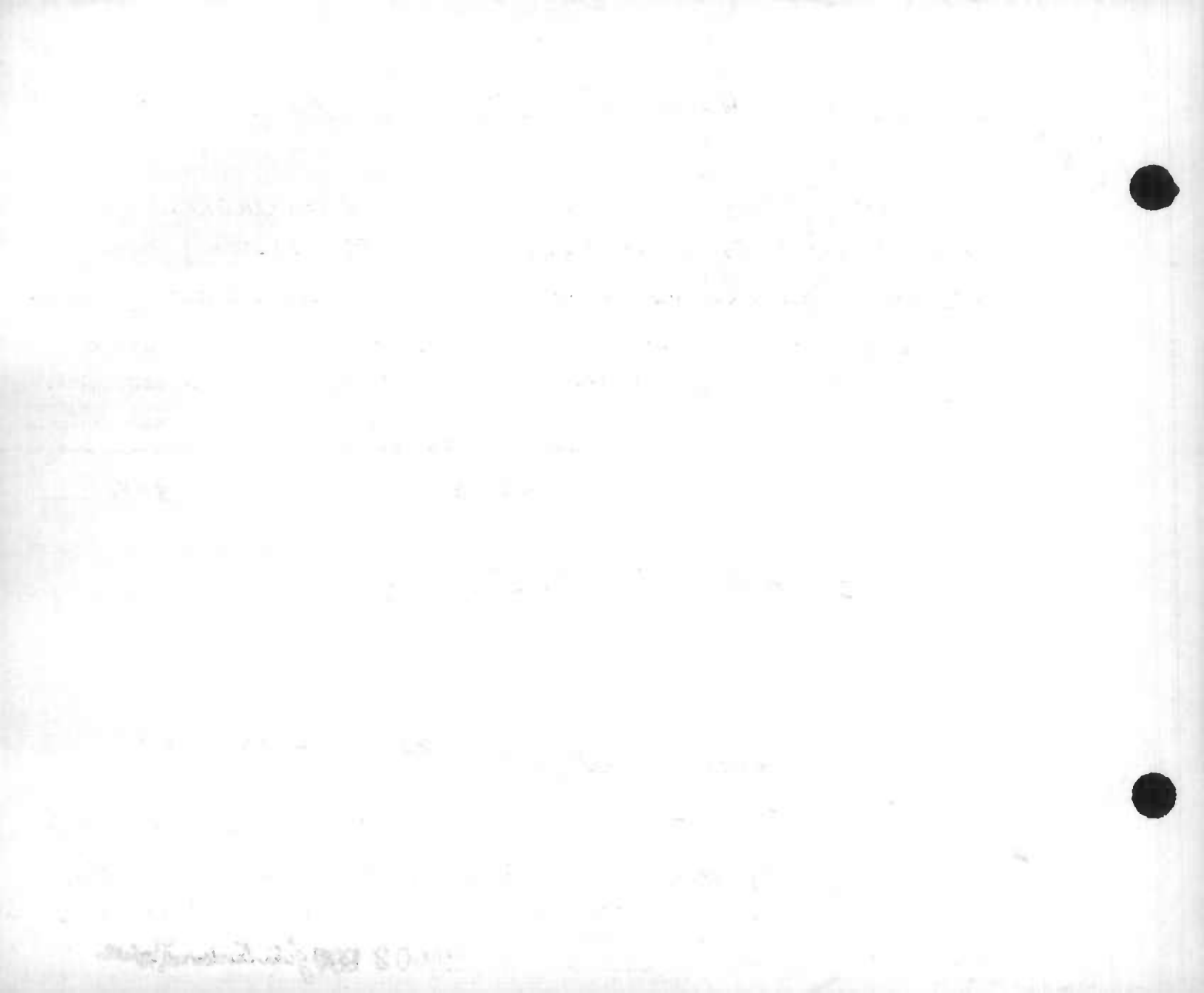
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELsie H. arritte JUDD			2a. DATE OF DEATH MONTH DAY YEAR APRIL 28 1984		2b. HOUR MIN. 6 35 P M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1890		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 93	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AVALON MANOR		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) diet kitchen		12b. KIND OF BUSINESS OR INDUSTRY hospital
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Walnut Towers 21740	
14. FATHER'S NAME FIRST MIDDLE LAST John D. Crawford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Stine			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-20-3987		17. INFORMANT ADDRESS David L. Judd, Sr., Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c) yes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) obs. Acute viral gastroenteritis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 4-27 19 84 , that (I) (we) last saw the deceased alive on 4-27 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 4-30-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. B. KAHN, M.D.		22e. ADDRESS 1933 Va. Ave. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL burial	23b. DATE May 1, 1984	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		ADDRESS 415 E. Wilson Blvd., Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE May 2 1984 [Signature]	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 3 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alice D. Kataline			2a. DATE OF DEATH MONTH DAY YEAR April 15, 1984		2b. HOUR M
1. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 8, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60	7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Time keeper		12b. KIND OF BUSINESS OR INDUSTRY Aircraft
13a. STATE Md.	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2427 Long Ridge Dr. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Earl Drury		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Loving			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 235-34-3850		17. INFORMANT ADDRESS 13 Greentree Lane Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis with bleeding esophageal varices DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Sepsis and renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WRITE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7, 19 79, to 4/15, 19 84, that (we) last saw the deceased alive on 4/15, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE George Newman II		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-18-1984		23c. NAME OF CEMETERY OR CREMATORY Davis	
23d. LOCATION CITY OR TOWN COUNTY STATE Davis, Tucker WV.					
24. FUNERAL DIRECTOR NAME Lester R. Hinkle Davis, WV.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE APR 24 1984 Julia Davidson-Rodalle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1941-1942

1943-1944

1945-1946

1947-1948

1949-1950

1951-1952

1953-1954

1955-1956

1957-1958

1959-1960

1961-1962

1963-1964

1965-1966

1967-1968

1969-1970

1971-1972

1973-1974

1975-1976

1977-1978

1979-1980

1981-1982

1983-1984

1985-1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 3 7

1 - FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) Margaret E. Keedy			2a. DATE OF DEATH MONTH DAY YEAR 4-11-84			2b. HOUR 4:35 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 28 1908		6. AGE (IN YEARS (LAST BIRTHDAY)) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? Maryland		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Nurse's Aid		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE Colton Villa Nurs. Home 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Huffer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Nelkirk			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 214-32-4105			17. INFORMANT ADDRESS Mrs. Anna Mae Grimm, Rd. 1 Box 68 Boonsboro, Md. 21713							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular and Peripheral 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4-5 , 19 84 , to 4-11 , 19 84 , that (I) (we) last saw the deceased alive on 4-11 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Eric M. Wagshal, MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-11-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric M. Wagshal, M. D.			22e. ADDRESS 1825 Howell Rd., Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (STATE) Burial			23b. DATE 4-14-84		23c. NAME OF CEMETERY OR CREMATORY Rohrersville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rohrersville, Wash. Co., Md.			
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.					ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR APR 16 1984		25b. REGISTRAR'S SIGNATURE Lia Davidson-Randall	

BP _____

1

My dear Sir,
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.
I am sorry to hear that you are not satisfied with the result of the investigation.
I have been very busy lately, and have not had time to devote to this matter as much as I would like.
I am sure that you will understand my position.
I am, Sir, very respectfully,
Your obedient servant,
J. H. [Name]

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Name]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

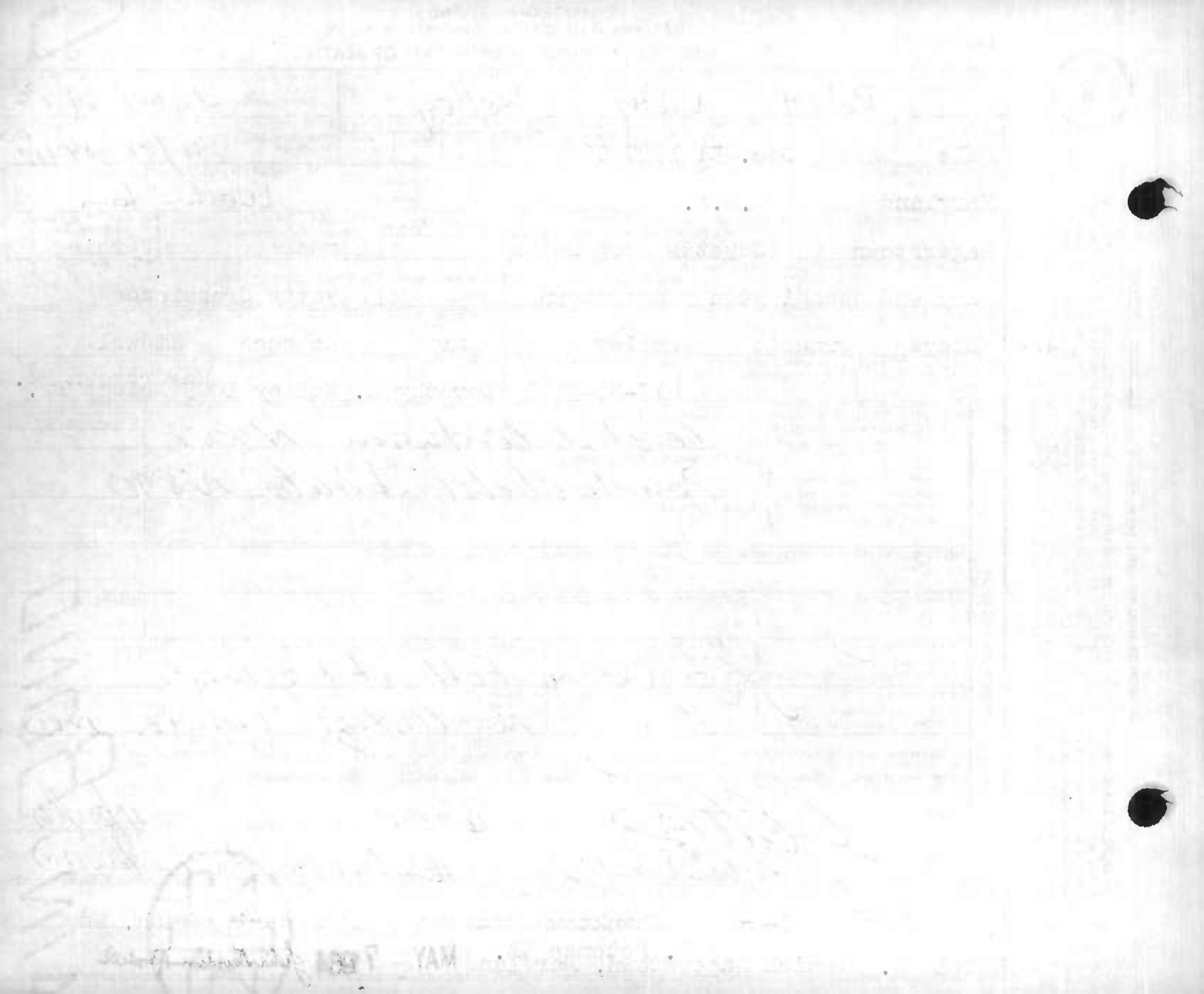
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

11838

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Robert Victor Kelley						2a. DATE KNOWN OF DEATH ESTIMATED 4/28/84		2b. HOUR 7:30 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 31 1927	6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 4/28 1984		2d. HOUR 11 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Huyetts Crossroads				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Huyetts Crossroads 2740	
14. FATHER'S NAME FIRST MIDDLE LAST Lloyd Francis Kelley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rebecca Kidwell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-30-5971		17. INFORMANT ADDRESS Dorothy R. Kelley 1005 Noland Dr. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Contusion N 851 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Possible alcohol intoxication N 890 DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:30 AM 4 28 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) Fell striking head.				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Farm		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Near Clearcrops Washington MD				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE [Signature]			TITLE (SPECIFY) Deputy Asst			MEDICAL EXAMINER		DATE SIGNED 4/28/84	
EXAMINER'S NAME (TYPE OR PRINT) Phyllis D. H. M.D.			ADDRESS 1610 Oak Hill Ave Hagerstown MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-1-84		23c. NAME OF CEMETERY OR CREMATORY Shanktown Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Clearspring Wash. Md		
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland			30 PRESS N Potomac St			25a. DATE REC'D. BY REGISTRAR MAY - 7 1984			
						25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be called on.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
FIRST MIDDLE LAST Arthur Bunn Keltner		04/26/84		5:20p M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Male	White	MONTH DAY YEAR 12/ 07/ 1898	85	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
			WASHINGTON Co. MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown	Washington County Hospital				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	
Md	Washington	Hagerstown	1079 View Street 21740		
14. FATHER'S NAME FIRST MIDDLE LAST John Keltner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Mae Nymen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
No		204-01-9391		Mr. Thurston Keltner, 733 Park Rd. Hagerstown Md. 21740	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Adenocarcinoma of Prostate with					3 years
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE LAST.					
DUE TO, OR AS A CONSEQUENCE OF widespread metastasis					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 9/10/78 to 4/26/84, that (I) (we) lost the deceased alive on 3/8/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Charles E. Spencer, M.D.		DEGREE M.D.		22c. DATE SIGNED 4-27-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Charles E. Spencer, M.D.		1198 Kenly Avenue; Hagerstown, Md. 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	Apr 30, 1984	Lincoln Cemetery	Chambersburg, Franklin, Pa.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Thomas L. Geisel		152 S. Second St. 17027		MAY - 7 1984	



BP

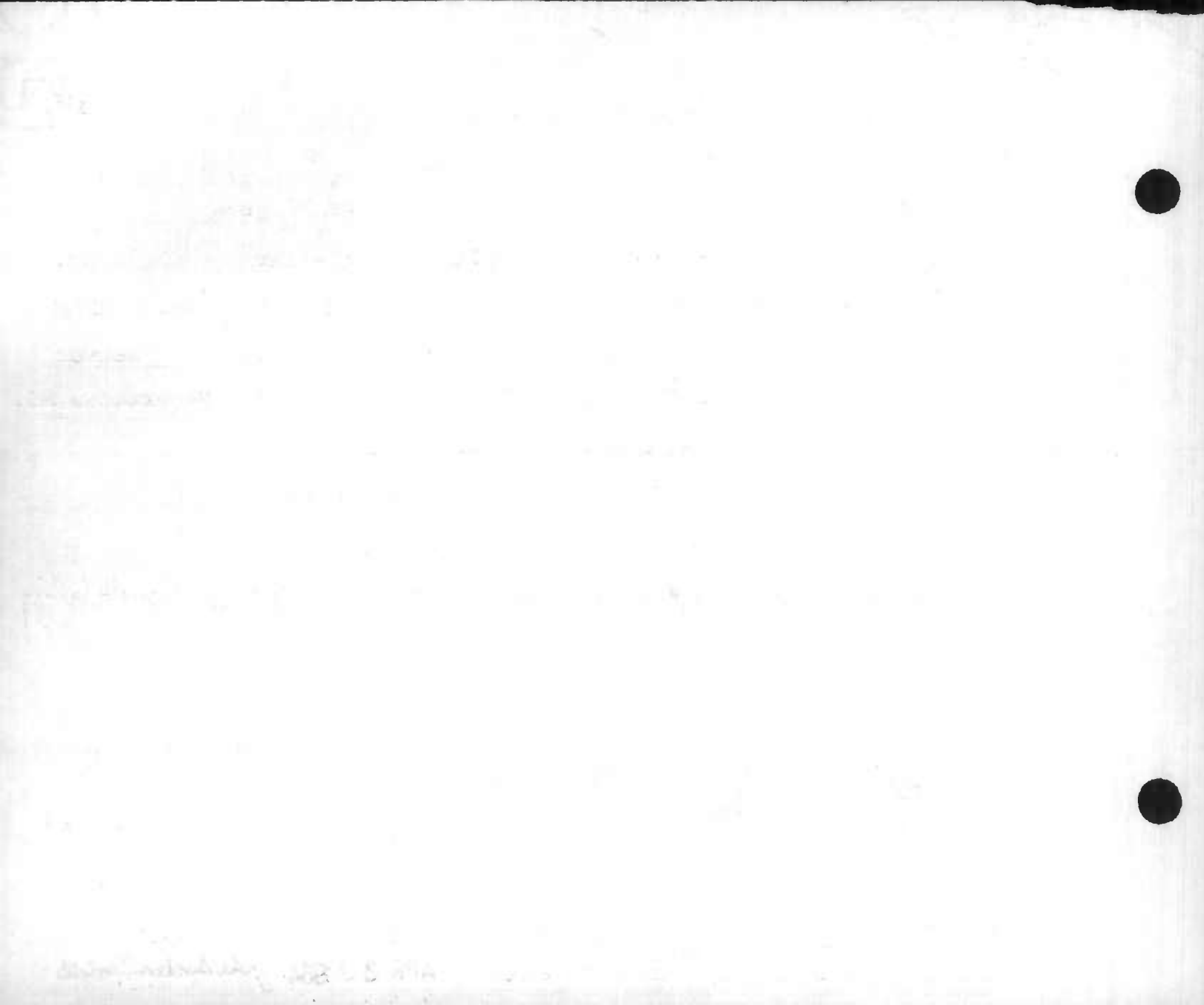
DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Emmert Franklin Knepper				04 24 84				12 ²⁵ P.M.			
3. SEX M		4. RACE White		5. DATE OF BIRTH 09 26 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) glazier		12b. KIND OF BUSINESS OR INDUSTRY Glass Co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 304 Woodhaven Dr. 21740			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown							
14. FATHER'S NAME FIRST MIDDLE LAST Frank John Knepper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May V. Weaver							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-1341		17. INFORMANT ADDRESS Charlotte E. Knepper, Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe atherosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Generalized ischemia of heart. Squamous carcinoma of lung. Cigarette smoking</u>											
19a. DATE OF OPERATION <u>4-24-84</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>4</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-24-84</u> 19 <u>84</u> , to <u>4-24-84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>4-24-84</u> 19 <u>84</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated other (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-24-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR APR 30 1984							
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8411841			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Roy Lind				April 18 '84 1:30 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 21 86		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH 21740 Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garlock Memorial Conv. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) yardman		12b. KIND OF BUSINESS OR INDUSTRY railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) 13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Woodsboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Roop Lind		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Elizabeth Shoemaker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 717-07-6788		17. INFORMANT Roy L. Lind		104 Creagerstown Rd. Woodsboro, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) Chemo							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							Years
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Post Gastrectomy							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/4, 1984, to 4/18, 1984, that (I) (we) lost saw the deceased alive on 4/17, 1984, and that in (my) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Durtsen, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Durtsen				22e. ADDRESS Hagerstown, MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/20/84		23c. NAME OF CEMETERY OR CREMATORY Haughs Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ladiesburg Frederick MD	
24. FUNERAL DIRECTOR NAME D. D. Garkler				25a. DATE REC'D. BY REGISTRAR APR 19 1984		25b. REGISTRAR'S SIGNATURE	

1944

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 4 2

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST Brumbaugh LAST Litton <i>Isaac B. Litton</i>		2a. DATE OF DEATH MONTH Apr DAY 18 YEAR 1984 2b. HOUR 8:53 A M	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH October DAY 29 YEAR 1918	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. 	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner		12b. KIND OF BUSINESS OR INDUSTRY service centers	
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST Wilson E. MIDDLE Litton LAST 		15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE LAST Mellott	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II	17. INFORMANT ADDRESS Margaret M. Litton, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Diabetes Mellitus			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 70 to 4-18 19 84 , that (I) (we) last saw the deceased alive on 4-18 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Charles C. Spencer</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4-18-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles C. Spencer		22e. ADDRESS 1198 Kenly Ave Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Apr. 21, 1984	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION CITY OR TOWN Hagerstown, Wash. COUNTY Maryland STATE
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR APR 23 1984	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

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Dr. A.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 4 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR			
James S Lively			4-2-84			8:10 PM		
1. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	MONTH	DAY	YEAR	68	MONTHS		DAYS
		Dec. 18		1915		YRS.		HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown		Washington County Hospital				Machinist		Truck Mfg.
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Penna.			Franklin		Waynesboro		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS / ZIP CODE		
FIRST MIDDLE LAST			FIRST MIDDLE LAST			603 Folger Ave. 99999		
Albert H. Lively			Mary Greathouse					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no			717-12-6755		Mrs. Caroline Lively 603 Folger Ave. 17268			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Anteroseptotic Coronary Vessel Disease		4 years	
2503 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus		20 years	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
Hypertension - Wilson Disease of Kidneys: Acute Chole Peritonitis			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 27, 1984 to Apr 2, 1984, that (I) (we) last saw the deceased alive on Apr 2, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
--

22b. SIGNATURE Robert Brull	22c. DATE SIGNED Apr 3, 1984
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull	22e. ADDRESS 1459 Potomac Street Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	4/5/1984	Green Hill Cemetery	Waynesboro Franklin Penna.

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Waynesboro, Penna.	APR 9 1984	John L. Brull



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RUTH FRANCES MARTIN			2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> APR. 8 1984			2b. HOUR 10:30 P.M.			
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 9, 1933	6. AGE (IN YEARS) (LAST BIRTHDAY) 50 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD APRIL 8 1984	7d. HOUR 10:58 P.M.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.			
12. CITY OR TOWN OF DEATH Hagerstown		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietary Dept. Worker		15. KIND OF BUSINESS OR INDUSTRY State Hosp.		
16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penna.		13b. COUNTY Franklin		13c. CITY OR TOWN Waynesboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 114 W. Main St.	
17. FATHER'S NAME FIRST MIDDLE LAST Charles Wills				18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma L. Eyler					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		19b. SOCIAL SECURITY NO. 215-36-5801		19c. INFORMANT ADDRESS Emmitsburg, Md.					
19d. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		19e. SOCIAL SECURITY NO. 215-36-5801		19f. INFORMANT ADDRESS Mrs. Debra J. Houck 9322 Waynesboro Pike					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) E-812 - MOTOR VEHICLE/MOTOR VEHICLE COLLISION 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) (SEVERE HEAD LACERATIONS; SKULL FRACTURE; BRAIN INJURY) (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MOMENTS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 9:07 P.M. APRIL 8 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) OPERATOR OF VEHICLE; SIDESWIPE BY PASSING VEHICLE					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) ROUTE #16		21f. LOCATION STREET CITY OR TOWN COUNTY STATE RT. #16 NEAR ROUZERVILLE, FRANKLIN, PENNA.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Edward W. Ditto</i>		TITLE (SPECIFY) DEPUTY			MEDICAL EXAMINER		DATE SIGNED APRIL 9, 1984		
EXAMINER'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.		ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/11/1984		23c. NAME OF CEMETERY OR CREMATORY Strang's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE South Mountain Franklin Penna.			
24. FUNERAL DIRECTOR NAME <i>And 4 Care</i>		ADDRESS 50 S. Broad St. Waynesboro, Penna.		25a. DATE REC'D. BY REGISTRAR 17 APR 1984		25b. REGISTRAR'S SIGNATURE <i>John H. ...</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, DIRECTOR OF HEALTH AND MENTAL HYGIENE SHALL BE ADVISED. TO FUNERAL DIRECTOR: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, DIRECTOR OF HEALTH AND MENTAL HYGIENE SHALL BE ADVISED. TO REGISTRAR: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, DIRECTOR OF HEALTH AND MENTAL HYGIENE SHALL BE ADVISED.

1

DATE: 7.9.1953

TO: ...

FROM: ...

SUBJECT: ...

RE: ...

REF: ...

1. ...

2. ...

3. ...

4. ...

5. ...

6. ...

7. ...

8. ...

9. ...

10. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>VIVIAN M. McCARTY</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>4/12/84</u> 4:10 PM		
3. SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Apr. 11 1914</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u>	
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Western Maryland Center</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Shop</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Brandt</u>			
13a. STATE <u>Maryland</u>		13b. CITY OR TOWN <u>Washington</u>		13c. STREET ADDRESS / ZIP CODE <u>Hagerstown 21740</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>John Myers</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Alice Hicks</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u>		16b. SOCIAL SECURITY NO. <u>217-10-2752</u>		17. INFORMANT ADDRESS <u>Etters, Penna. 17319</u> <u>Ralph E. McCarty Rt. 1 Box E 325</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Diabetes Mellitus</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>4/12</u> 19 <u>84</u> to <u>4/12</u> 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4/12</u> 19 <u>84</u> and that in (my our) opinion death occurred on the date and hour and from the causes stated above, (I we did) <input checked="" type="checkbox"/> view the body after death.					
22b. SIGNATURE <u>Rose Marie Chan, M.D.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>4/12/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROSE MARIE CHAN, M.D.</u>		22e. ADDRESS <u>1500 Pennsylvania Ave. Hagerstown</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>4-14-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
24. FUNERAL DIRECTOR NAME <u>Gerald N. Minnich</u>		305 N. Potomac St. <u>Hagerstown, Maryland</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 19 1984</u>	
				25b. REGISTRAR'S SIGNATURE <u>Gelia Davidson</u>	

BP

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR VIOLA MARGARET MC CLAIN

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VIOLA M MCCLAIN			2a. DATE OF DEATH MONTH DAY YEAR Apr 15 1984			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 4 1895		6. AGE (IN YEARS LAST BIRTHDAY) 88		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2316 Jefferson Blvd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2316 Jefferson Blvd. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Edward Carper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice Harris Marker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-09-5653		17. INFORMANT ADDRESS Walter E. McClain 104 Donnybrook Drive Hagerstown, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Adenocarcinoma of the Common Bile Duct**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 year

1561
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-26 1982 , to 4-15 1984 , that (I) lost saw the deceased alive on March 19 84 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death.							
22b. SIGNATURE Charles Spencer MD				DEGREE MD		22c. DATE SIGNED 4-16-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES C. SPENCER				22e. ADDRESS 1198 Kenty Ave Hagerstown Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-18-84		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Washington, Md.	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown,				25a. DATE REC'D. BY REGISTRAR APR 19 1984			
ADDRESS Julia Davidson				25b. REGISTRAR'S SIGNATURE Julia Davidson			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

• • •

Source: *Author's calculations*.

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Kenneth H Mechem										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 4 19 84										2b. HOUR 35 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9/7/40		6. AGE (IN YEARS) (LAST BIRTHDAY) 43 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 19 84				7d. HOUR 35 AM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD											
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver				12b. KIND OF BUSINESS OR INDUSTRY Trucking							
13a. STATE WV										13b. COUNTY Morgan		13c. CITY OR TOWN Great Cacapon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 364 99999							
14. FATHER'S NAME FIRST MIDDLE LAST Dwight Mechem				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Holliday																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1959-1962		17. INFORMANT Darlene Mechem		ADDRESS PO Box 364, Gt. Cacapon, WV															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8219 IMMEDIATE CAUSE (a) Crushing injury to skull N854 DUE TO, OR AS A CONSEQUENCE OF (b) Caught between objects E918 DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:55 P.M. 4 18 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Cal of truck fell on head															
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) I-70 East				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rest area just into Frederick Ct.															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Dist Asst				MEDICAL EXAMINER				DATE SIGNED 4/19/84											
EXAMINER'S NAME (TYPE OR PRINT) Allen W Ditt				ADDRESS 1600 Oak Hill Ave Hagerstown MD																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/21/84				23c. NAME OF CEMETERY OR CREMATORY Mt. Nebo Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Great Cacapon, Morgan, WV											
24. FUNERAL DIRECTOR NAME Helsley-Johnson F.H., Berkeley Springs, WV				ADDRESS 306 Union St. 25411				25a. DATE REC'D. BY REGISTRAR APR 26 1984				25b. REGISTRAR'S SIGNATURE [Signature]											

(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

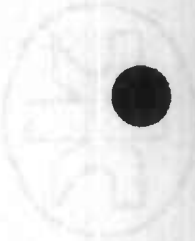
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Evelyn Ruth Meyer</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>April 14 84</i>			
3. SEX <i>Female</i>				2b. HOUR <i>8:15 AM</i>			
4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 19 1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington County MD.</i>			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry C. White</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bessie Thompson</i>		13e. STREET ADDRESS <i>RT 8, Box 804</i> 21740			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-07-3828</i>		17. INFORMANT ADDRESS <i>Mr. Edward C. Meyer, Hagerstown, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>1629</i> IMMEDIATE CAUSE (a) <i>Cause of Lung</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W.W. L. MD</i> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4-17-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>Apr. 17, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Lawn Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i> ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 19 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Anderson</i>	

BP

1971-1972



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with SV2 (Burial) and with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and/or retained.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel May Middlekauff				2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14 1893		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Coffman Home for the Aged		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Pub. Health	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN Maryland Washington Hagerstown				13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Franklin Middlekauff				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Ann Jacques			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-40-3715		17. INFORMANT ADDRESS Ethel C. Hohman Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 Pneumia DUE TO, OR AS A CONSEQUENCE OF (b) Chronic bronchitis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 14 Apr 1984 to 15 Apr 1984 , that (I) (we) last saw the deceased alive on 14 Apr 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. N. Minnich		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-18-84		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		24b. ADDRESS 305 N. Potomac St. Hagerstown, Maryland					

BP

(A)

[Faint, mostly illegible text on lined paper, possibly bleed-through from the reverse side. Some words like "The" and "and" are visible.]

APR 2 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 657

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) John Howard Milhollen					2a. DATE OF DEATH MONTH DAY YEAR HOUR 4 14 84 9:04 PM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 07-22-19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13e. STREET ADDRESS 125 N. Prospect 21740			
14. FATHER'S NAME FIRST MIDDLE LAST John H. Milhollen, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Ramsey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown			16b. SOCIAL SECURITY NO. 578-40-0880		17. INFORMANT ADDRESS Dorcas Black, Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) Pnumonica DUE TO, OR AS A CONSEQUENCE OF (b) Advamced Organic Brain Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Afteriosclerotic									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR None 10 5 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Pt fell and sprind Rt Hand					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural									
22b. SIGNATURE ABDUL LATHEEF				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/17/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL LATHEEF MD				22e. ADDRESS 1600 Oak Hill Ave. Hagerstown 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Apr. 17, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740									
DATE RECEIVED BY REGISTRAR 25. REGISTRAR'S SIGNATURE APR 23 1984									

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ellen Ruth Miller			2a. DATE OF DEATH MONTH DAY YEAR 4-1-84		2b. HOUR 1:05 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 9-2-1896	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahrney-Keedy Mem. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE md.			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Ehrhart			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma R. Albert		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-6950	17. INFORMANT ADDRESS Richard Miller, Newark, Del.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic breast carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE uh ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAHEED		22e. ADDRESS 1000 OAK HILL AVE HAGERSTOWN, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE April 4, 1984		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21744			
25a. DATE REC'D. BY REGISTRAR APR 5 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randells			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1-1-31 100

Ellen Ruth Miller

Female Caucasian 9-2-1891

Washington X

Exonors former-head Washington

Washington Washington X

John Thomas Edward

10-11-1890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 11852
1. DECEASED NAME (TYPE OR PRINT) Mildred Dean MOORE					2a. DATE OF DEATH MONTH DAY YEAR 4 17 1984			2b. HOUR 7:15A.M.		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Apr. 1, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE N. Cannon Ave. 21740			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown						
14. FATHER'S NAME FIRST MIDDLE LAST Andrew J. Stottlemeyer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Ellen Stem						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-46-3365		17. INFORMANT ADDRESS Helen Strock, Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 4100 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ATHEROSCLEROTIC HEART DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 months once before										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic Obstructive Pulmonary Disease; Emphysema; Respiratory Failure; Renal Failure										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 4, 1984 to APRIL 17, 1984 , that (I) (we) lost saw the deceased alive on April 16, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE DINO J DELAPORTAS			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DINO J DELAPORTAS, MD			22e. ADDRESS 703 OAK Hill AVE. HAGERSTOWN, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Apr. 20, 1984		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.		
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR APR 23 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodell				
415 E. Wilson Blvd., Hagerstown, Md.										

BP

APR 2 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

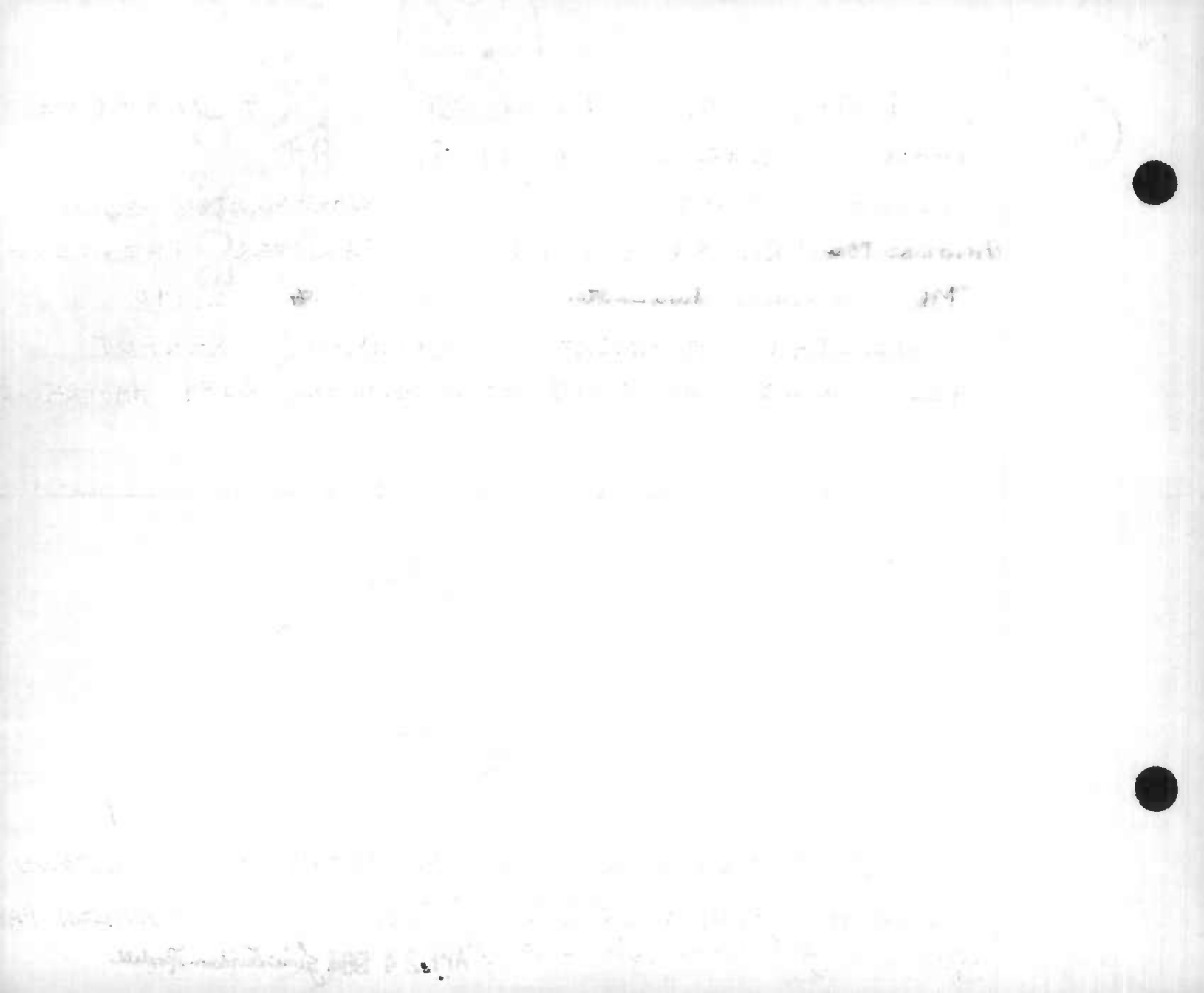
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

11853

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST		4 17 84		8:30 AM	
Luther M Mummert					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR IF UNDER 24 HRS.	
male	WHITE	MONTH DAY YEAR	94	YRS.	
11 18 89					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
PENNA.	USA		WASHINGTON COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN	R.D. #4 Box 299		PAINTER		PAINTING
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MD.	WASHINGTON	HAGERSTOWN	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	RT #4 21740	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
WILLIAM MUMMERT	KATHRYN KERFOT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
YES	WWI	LEILA MUMMERT	R.D. #4 HAGERSTOWN		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY					
4149 IMMEDIATE CAUSE (a) <i>Cardiovascular arrest</i>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <i>Arterio Heart Disease</i>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <i>5 years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
<i>Coronary & the prostate - Pulmonary Embolism</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>Oct 1978</i> to <i>April 17 1984</i> , the <i>(b)</i> (we) last saw the deceased alive on <i>2-3</i> 19 <i>84</i> , and that <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE				22c. DATE SIGNED
<i>Robert J. Trace Jr.</i>					<i>4-17-84</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
ROBERT J. TRACE JR.	119 E. ANTIETAM ST. HAGERSTOWN				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL	4/21/84	MALEDONIA CHURCH CEMETERY	FRANKLIN PA.		
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
<i>Arnold H. Zimmerman</i>	APR 24 1984	<i>Julia Davidson Rodale</i>			

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the county after death. Page 3 should be retained by the funeral director.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

11854

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES M. MYERS			2a. DATE OF DEATH MONTH DAY YEAR 4-30-84			2b. HOUR 8:10 PM	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 10 05 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital Hager, MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY meats wholesale	
13a. STATE Pennsylvania		13b. COUNTY Franklin		13c. CITY OR TOWN Greencastle		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST R. Albert MYERS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie M. Scholtz		16. STREET ADDRESS / ZIP CODE 10512 Letzburg Road 17225		17. ADDRESS Greencastle, Pa.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT Betty J. Myers		17. ADDRESS 10512 Letzburg Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. R. [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAKID		22e. ADDRESS 1600 Oak Hill Ave Hager, MD 21740					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE May 3/1984		23c. NAME OF CEMETERY OR CREMATORY Macedonia Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Antrim Twp. Franklin Co. Pa.	
24. FUNERAL DIRECTOR NAME ADDRESS MARVIN MILLER - Greencastle, Pa.		25a. DATE REC'D. BY REGISTRAR MAY 4 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers			



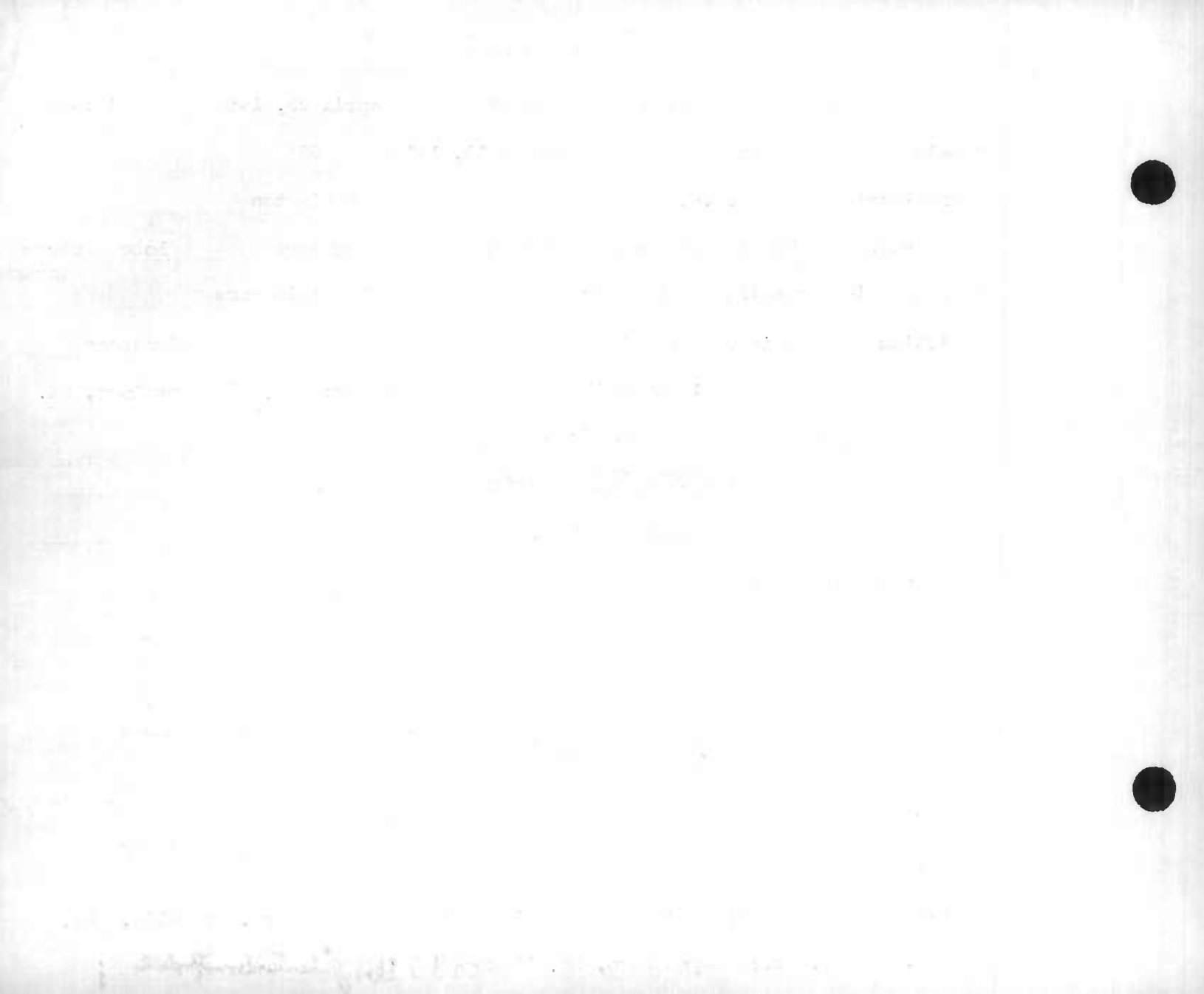
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

11855

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EVA LORRAINE NEEDY			2a. DATE OF DEATH MONTH DAY YEAR April 25, 1984		2b. HOUR 12:05p M				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 17, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Globe Pattern Works	
13a. STATE Pennsylvania		13b. COUNTY Franklin		13c. CITY OR TOWN Waynesboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 713 Maple Street 99999	
14 FATHER'S NAME FIRST MIDDLE LAST William Steiner Humerick			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Mae Firestone						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 173-03-2013		17 INFORMANT ADDRESS Jack B. Enslinger; R.D. #5 Waynesboro, PA.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5849 IMMEDIATE CAUSE (a) CARDIOPULMONATORY ARREST						17268		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE Heart Failure									
DUE TO, OR AS A CONSEQUENCE OF (c) Acute Renal Failure									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hypertension.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-18 , 19 84 , to 4-25 , 19 84 , that (I) (we) lost saw the deceased alive on 4-25 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eli Roza				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-25-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELI ROZA				22e. ADDRESS WASHINGTON COUNTY HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 28/84		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro, Franklin, PA.			
24. FUNERAL DIRECTOR NAME John S. Snyder, Jr.;				ADDRESS Waynesboro, PA. 17268		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 30 1984 Julie Davidson-Rondelle			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

11856

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence May Nicklas			2a. DATE OF DEATH MONTH DAY YEAR April 2 1984		2b. HOUR M AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 12 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 673 Oak Hill Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 220 N. Potomac St.
14. FATHER'S NAME FIRST MIDDLE LAST Charles Seford Tosten			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie L. Long		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Frances L. Nicklas 1052 H. Noland Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hypertension					
19a. DATE OF OPERATION 4-4-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 24 April 1969 to 2 April 1984 , that (I) (we) lost saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. N. Fender		DEGREE M.D.		22c. DATE SIGNED 4 April 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. N. Fender		22e. ADDRESS 130 E. Antietam St., Hagerstown, Md 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 4-4-84	23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory Smithsburg Wash. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		ADDRESS 305 N. Potomac St. Hagerstown, Maryland		25. DATE REC'D BY REGISTRAR APR 12 1984	
26. REGISTRAR'S SIGNATURE J. H. Fender					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

11857

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Albert Gibson Packard SR.			2a DATE OF DEATH MONTH DAY YEAR April 11, 1984			2b HOUR M			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR May 3, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Dakota		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) director		12b KIND OF BUSINESS OR INDUSTRY city schools	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST George Weston Packard				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Pollard					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.I		17 INFORMANT ADDRESS Dr. Albert G. Packard, Jr. Easton, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Pulmonary Obstructive Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <u>7 April</u> 19 <u>84</u> to <u>11 April</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11 April</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>E Howell Cude MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c DATE SIGNED <u>4/11/84</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>E Howell Cude MD</u>						22e ADDRESS <u>Hagerstown Md.</u>			
23a BURIAL, CREMATION, REMOVAL SPECIAL <u>burial</u>			23b DATE Apr. 14, 1984		23c NAME OF CEMETERY OR CREMATORY Denton Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Denton, Md.		
24 FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a DATE REC'D. BY REGISTRAR APR 16 1984		25b REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

(2)

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SUMALEE -NMN- PENDERGAST			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Apr 25 1984			2b. HOUR 8:00 PM		
3. SEX Female	4. RACE Orient	5. DATE OF BIRTH MONTH DAY YEAR Nov. 11, 34	6. AGE (IN YEARS) (LAST BIRTHDAY) 49 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD Apr. 25 1984		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Thailand		7b. CITIZEN OF WHAT COUNTRY? Thailand		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1104 Maugans Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Pra Khumsup			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sa Khumsup			13e. STREET ADDRESS 21740 1104 Maugans Ave.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS James R. Pendergast/same as 13 e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9530 IMMEDIATE CAUSE (a) Hanging - E-913 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 8:00 P.M. Apr 25 1984			21b. TIME OF INJURY HOUR AM: MONTH DAY YEAR 8:00 P.M. Apr 25 1984			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Hanged Self From Rafter in Basement		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE Maugans Ave. Hagerstown Wash Md		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Edward W. Dixon III			TITLE (SPECIFY) Detective			DATE SIGNED Apr 25, 1984		
EXAMINER'S NAME (TYPE OR PRINT) Edward W. Dixon III MD			ADDRESS 217 W. Washington St Hagerstown, Md 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4/27/84		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory Smithsburg, Wash. Md.			
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel			25. DATE OF DEATH APR 30			25. SIGNATURE OF REGISTRAR J. H. H. H. H.		
1601 Pennsylvania Ave. / Hagerstown Md 21740								

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DO NOT WRITE IN THESE SPACES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George Lewis Pike			2a. DATE OF DEATH MONTH DAY YEAR 4-3-84			2b. HOUR M AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 25 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Walnut Towers		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office		12b. KIND OF BUSINESS OR INDUSTRY Fairchild	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 11 A. Walnut St. apt. 501		14. FATHER'S NAME FIRST MIDDLE LAST Philip Sheridan Pike		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret B. Stickell		16. Hager. Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 221-10-3236		17. INFORMANT ADDRESS Beatrice J. Bitterof 924 Oak Hill			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **2500**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Diabetes mellitus**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Chronic Hypertension**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Years

Years

Years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct , 19 78 , to 2 April , 19 84 , that (I) (we) last saw the deceased alive on May 12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. Hoachlan				DEGREE Attending Physician		22c. DATE SIGNED 4/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Hoachlan				22e. ADDRESS Hagerstown Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-5-84		23c. NAME OF CEMETERY OR CREMATORY Macedonia Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greencastle Pen na.	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich				ADDRESS 305 N. Potomac St.		25a. DATE REC'D. BY REGISTRAR APR 12 1984	
				25b. REGISTRAR'S SIGNATURE Gerald N. Minnich			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpages 1, 2, and 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maude E. PITZER				April 20, 1984			
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 7 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Village		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager Apple Orchard		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE W.Va.		13b. COUNTY Berkeley		13c. CITY OR TOWN Martinsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Payne		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Isabelle Rinker		13e. STREET ADDRESS Route # 1		99999	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-36-7204		17. INFORMANT ADDRESS Patricia Pitzer, WV			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) Acute pneumonia, LLC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) BECD							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 4-18 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W.B. KONG, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-20-84	
22d. PHYSICIAN NAME (TYPE OR PRINT) W.B. KONG, M.D.		22e. ADDRESS 1933 Va. Ave. Hagerstown, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 23, 1984		23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Martinsburg Berkeley W.Va.	
24. FUNERAL DIRECTOR NAME Gerald Minnich				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Apr 27 1984			
ADDRESS S. Potomac St. Hagerstown, Md							



General Winston B. Thomas St. Petersburg, Florida
April 27, 1964
Honorable Secretary
Department of Defense
Washington, D.C.

Dear Sir:
Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.
Very truly yours,
Joseph W. Bland
Assistant Secretary

W. B. Bland
Assistant Secretary
Department of Defense
Washington, D.C.

Enclosure
Very truly yours,
Joseph W. Bland
Assistant Secretary
Department of Defense
Washington, D.C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Lizzie Evers Price</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 17 84</i>			2b. HOUR <i>11:50 A.M.</i>				
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Apr. 30, 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.				
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>owner</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>grocery store</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>					13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <i>21740</i> <i>1075 Jefferson Blvd.</i>										
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles W. Plummer</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah Ellen Bachtell</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <i>Frederick Price, Hagerstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST <i>4100</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>		
								<i>2 hours</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Recent myocardial infarction on April 13, 1984</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>4-17-84</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>4-12-84</i> to <i>4-17-84</i> , that (I) (we) last saw the deceased alive on <i>4-17-84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (old) (did not) view the body after death.										
22b. SIGNATURE <i>WS Hood MD</i>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <i>4-17-84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>WS Hood</i>			22e. ADDRESS <i>HAG-</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>			23b. DATE <i>Apr. 20, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>			ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md.</i>		25. REGISTRAR'S SIGNATURE <i>APR 23 1984 [Signature]</i>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

02477 DT 3 J
1942

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445220-102584

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST RUBY	MIDDLE MAE	LAST RIDENOUR	2a. DATE OF DEATH MONTH DAY YEAR April 4, 1984		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 20, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clearview Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 10, Box 43 21740		
14. FATHER'S NAME FIRST MIDDLE LAST George - Carper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie - Dunlap						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-24-9335		17. INFORMANT ADDRESS V. Dale Ridenour, Hagerstown, MD 21740						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Measles</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Years</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Mos.</u> <u>Years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>2 pm</u> 19 <u>84</u> , to <u>4 am</u> 19 <u>84</u> , that (I) viewed saw the deceased alive on <u>2 pm</u> 19 <u>84</u> , and that in (my) low opinion death occurred on the date and hour and from the causes stated above, (I) did <u>did not</u> view the body after death.										
22b. SIGNATURE <u>J.D. Wilson, M.D.</u>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/8/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.D. WILSON, M.D.				22e. ADDRESS 580 Northern Ave., Hagerstown, MD 21740						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 7, 1984		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash. MD				
24. FUNERAL DIRECTOR NAME <u>Dennis & Davis</u> ADDRESS Davis Funeral Home, Smithsburg, MD 21783				25. REGISTRAR'S SIGNATURE <u>J. D. Wilson</u>						

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

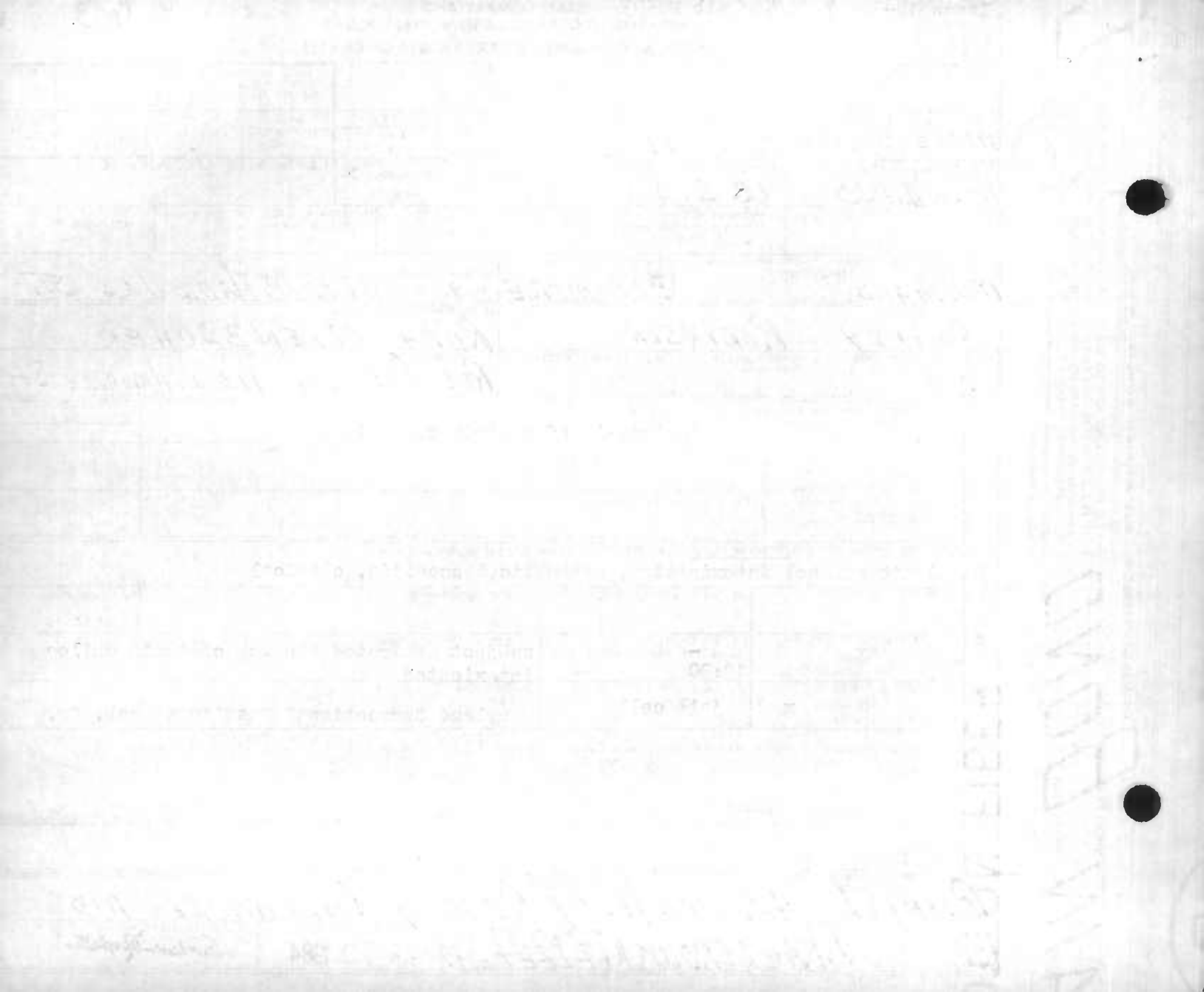
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Alfred D. Robinson								4/24/84		19						M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	WHITE	10 22 61		22 YRS.						4/24/84		19				P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND		U. S. A.				Washington County										MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Hagerstown		Hospital Rm. - Md. Correctional Insti.															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1130 W. HAMBURG ST.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
SMITTY		ROBINSON		RUBY OFFENBACHER													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO				RUBY ROBINSON		1130 W. HAMBURG ST.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Aspiration of gastric contents</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
9110				DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>													
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Acute ethanol intoxication, asthmatic bronchitis, clinical															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		subject aspirated stomach contents while intoxicated											
10:30 AM		19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		Maryland Correctional Institute Wash. Co.											
		Jail cell															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		4/25/84											
AK-10		Assistant															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Gregory R. Kauffman, M.D.		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
BURIAL		4-28-1984		Holy ROSARY		BALTIMORE		MD									
FUNERAL DIRECTOR		2525 FLEET ST		DATE REC'D. BY REGISTRAR		2525 FLEET ST		APR 30 1984									
RAYMOND L. KACZOROWSKI																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with 72 hours after death should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MELVEN E. ROBINSON			2a. DATE OF DEATH MONTH DAY YEAR 4-20-84			2b. HOUR 6:00 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co., MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto mechanic	
12b. KIND OF BUSINESS OR INDUSTRY automobile							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Pa. Franklin County							
13b. CITY OR TOWN Mercersburg		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 10324 Reeder Rd. 99999			
14. FATHER'S NAME FIRST MIDDLE LAST Charles I. Robinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Catherine Shives			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 188-10-0540		17. INFORMANT ADDRESS 10324 Reeder Rd. Helen Robinson Mercersburg, Pa. 17236			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4100 IMMEDIATE CAUSE (a) cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute M.I.
DUE TO, OR AS A CONSEQUENCE OF
(c) ASHD

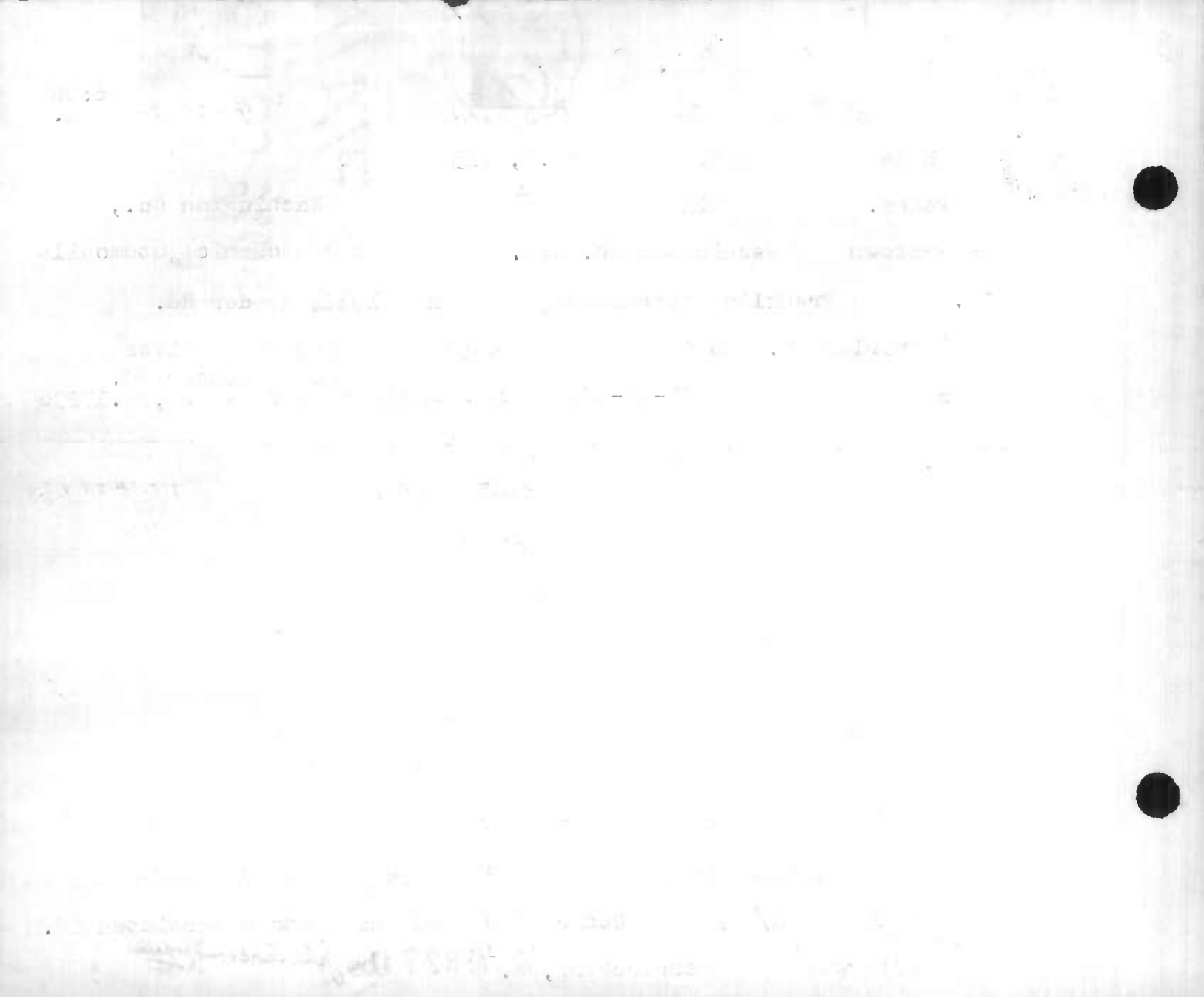
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

less than 1 hr.

YMS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. B. KAWA, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-20-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. B. KAWA, M.D.		22e. ADDRESS 1933 Va. Ave., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/23/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Washington Md.	
24. FUNERAL DIRECTOR T. M. Smiley		ADDRESS 17236 Mercersburg, Pa.		25. DATE REC'D. BY REGISTRAR APR 27 1984			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR 1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		MONTH		DAY		YEAR		7b. HOUR	
		FIRST MIDDLE LAST Wesley Marvin Roby		4 10 84		7:14						M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.			
Male		White		MONTH DAY YEAR 6 13 64		59 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Washington Co.						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington County Hospital		Plumber		Plumbing							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
		Pa.		Needmore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Br. 150 B				99999	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST Guy Roby		FIRST MIDDLE LAST Myrtle Hamilton											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
YES		LOW II.		212-20-1033		Bonnie Roby		Br. 150 B		Needmore Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
5740 IMMEDIATE CAUSE (a)		30 min		pneumonia									
DUE TO, OR AS A CONSEQUENCE OF				(b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF		(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				Carcinoma of the lung									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
4/5/84		Acute Cholecystitis; Cholelithiasis		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
21g. I certify that (I) (this hospital) attended the deceased from Jan 1984, to April 1984, that (I) (we) last saw the deceased alive on April 9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
		MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
C. S. H. MD		201 S. Cleveland Ave. Hagerstown Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		4/13/84		Needmore Bible Church Cem		Needmore Fulton Pa							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Rodger Cornelius		322 N. 2nd St. Mt Connellsburg Pa		APR 17 1984		Julia Davidson							

Page 10

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

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references.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAUDE MAUDE ELIZABETH ROWE ROWE			2a. DATE OF DEATH MONTH DAY YEAR APRIL 14, 1984			2b. HOUR A M 3:58			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 25, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 20 College Avenue 21701	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Spalding				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Philips					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-38-1623		17. INFORMANT Mrs. Judith A. Young		ADDRESS p. O. Box 732 Frederick, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4850 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute Renal Failure DUE TO, OR AS A CONSEQUENCE OF Acute Renal Failure (c) 2nd Duodenal Ulcer APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks. days. 4-13									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Renal Insufficiency									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/13/84 , 19, to 4/14/84 , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/13/84 , 19, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.									
22b. SIGNATURE MICANINIA M.O.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICANINIA M.O.			22e. ADDRESS 1500 Pr. Ave. Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/17/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Maryland		
24. FUNERAL DIRECTOR Dailey & Son 1201 W. Market St. Frederick, Md. 21701									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

11867

1. DECEASED NAME (TYPE OR PRINT) Michael Marco MIDDLE Salvia LAST SALVIA		2a. DATE OF DEATH MONTH DAY YEAR APRIL 21 1984		2b. HOUR 9:15 A M	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1897	
6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 212 Maple Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	
12b. KIND OF BUSINESS OR INDUSTRY Western Union					
13a. STATE Md.		13b. COUNTY Wash,		13c. CITY OR TOWN Hagerstown	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 1 Box 190 21740			
14. FATHER'S NAME FIRST MIDDLE LAST Gabriel Salvia		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aurelia Rossano			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 056-10-7876A		17. INFORMANT ADDRESS Mrs. Marie Z. Salvia Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) MINORS YES					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 65 to April 21 , 19 84 , that (I) (we) last saw the deceased alive on 21 April , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE HAROLD R. TRITCH JR MD		DEGREE MD		22c. DATE SIGNED 4-22-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD R. TRITCH JR MD		22e. ADDRESS 138 E. ANTIETAM ST HAGERSTOWN, Md 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 25, 84		23c. NAME OF CEMETERY OR CREMATORY St. Raymond's Cemetery	
23d. LOCATION CITY OR TOWN Bronx		COUNTY Bronx		STATE N.Y.	
24. FUNERAL DIRECTOR NAME Dennis L. Davis		24b. ADDRESS Smithsburg, Md.		24c. DATE RECEIVED BY REGISTRAR APR 25 1984	

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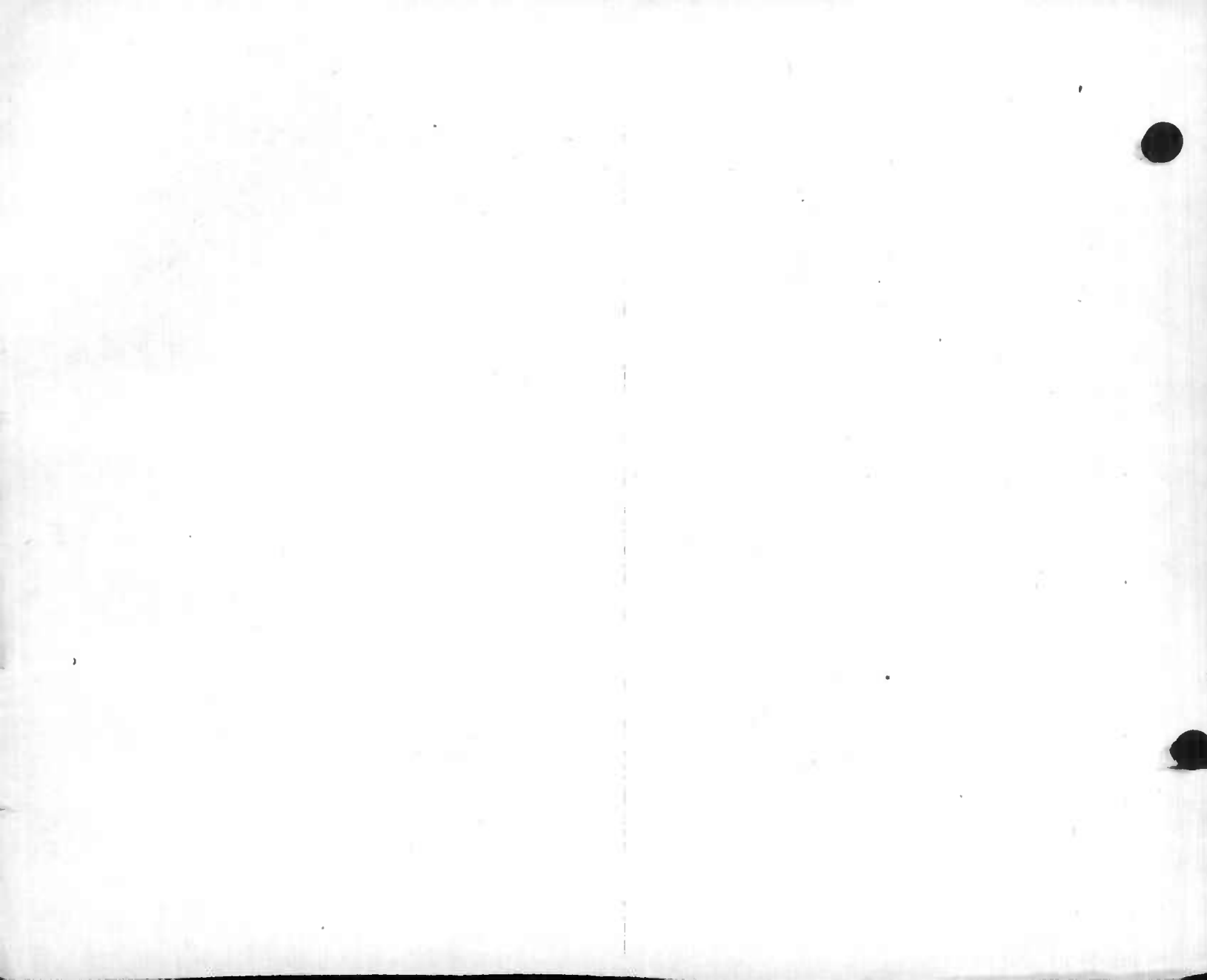
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SEE CERTIFICATE #84-34940

William Edward Seibert - Wash.Co. , 4/23/84



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) <i>Chester Berlin Schaffer</i>						2a. DATE OF DEATH MONTH <i>4</i> DAY <i>8</i> YEAR <i>84</i>		2b. HOUR <i>M</i>		
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH <i>July</i> DAY <i>20</i> YEAR <i>1920</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.				
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Co. Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>inspector</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>city</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST <i>William</i> MIDDLE <i></i> LAST <i>Shaffer</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Edith</i> MIDDLE <i>M.</i> LAST <i>Winters</i>			13e. STREET ADDRESS <i>21740 824 W. Washington St.</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>W.W.II 232-24-3694</i>		17. INFORMANT ADDRESS <i>Mrs. C.Ecile Shaffer, Hagerstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <i>Multiple Pulmonary Emboli</i> <i>4519</i> DUE TO, OR AS A CONSEQUENCE OF: (b). <i>Thrombophlebitis</i> DUE TO, OR AS A CONSEQUENCE OF: (c). <i>Hip Replacement Surgery</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Severe Organic Heart Disease with Valvular Disease</i>										
19a. DATE OF OPERATION <i>3-8-84</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Osteoarthritis Degenerative Hip Disease-</i>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <i></i> A.M. <i></i> MONTH <i></i> DAY <i>19</i> YEAR <i></i> P.M. <i></i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <i></i> CITY OR TOWN <i></i> COUNTY <i></i> STATE <i></i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> 19 <i>84</i> , to <i>April</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>April 7</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>Mary E. Money MD.</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4/10/84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mary E. Money MD</i>						22e. ADDRESS <i>1708 Oak Hill Ave Hagerstown, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>			23b. DATE <i>Apr. 11, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Lawn Mem. Park</i>		23d. LOCATION CITY OR TOWN <i>Hagerstown</i> COUNTY <i>Wash.</i> STATE <i>Md.</i>			
24. FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i> ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>						25a. DATE REC'D. BY REGISTRAR <i>APR 12 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Shirley Davidson-Rindone</i>		

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Multiple handwritten notes and signatures, including "Multiple handwritten notes" and "Multiple handwritten notes".

Multiple handwritten notes and signatures, including "Multiple handwritten notes" and "Multiple handwritten notes".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gertrude J Shantz					2a. DATE OF DEATH MONTH DAY YEAR 4/9/84		2b. HOUR 7P M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 4 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY Resturant	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 4 Box 179 21740	
14. FATHER'S NAME FIRST MIDDLE LAST John Russell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Albert				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-30-7831		17. INFORMANT ADDRESS Sharon W. Shantz Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrhythmia min 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) congestive heart failure days DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic heart disease yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that X (this hospital) attended the deceased from 323 19 84 to 4/9 19 84 that X (we) lost saw the deceased alive on 4/9 19 84, and that in (my) (xxx) opinion death occurred on the date and hour and from the causes stated above. (If not, did not see the body after death.)									
22b. SIGNATURE Hob Pdw				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-11-84		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.			
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 12 1984 [Signature]					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nora Emily SHINGLETON			2a. DATE OF DEATH MONTH DAY YEAR April 4, 1984			2b. HOUR 2:45 P.M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan. 20, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Bidle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Brain						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 217-18-7307		17. INFORMANT Ruth E. South, Hagerstown, Md.			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart Disease +</u> <u>5860</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>25 yrs</u> <u>60 days</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (we) attended the deceased from <u>MAY 16</u> , 19 <u>82</u> , to <u>APRIL 3</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>APRIL 3</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Edward W. D. Ditto</u> DEGREE						22c. DATE SIGNED APRIL 4, 1984			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.						22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE Apr. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR APR 6 1984			
						25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages beyond 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or the medical officer of health or health officer should be notified.

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215 T. LAMINGTON STREET
BAGGERTON, MARYLAND 21030

EDWARD E. DITTO, III, M.D.

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APR 15

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Mary Elizabeth Shives</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>April 10 1984</i>		2b. HOUR M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 6, 1909	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		6b. CITIZEN OF WHAT COUNTRY? UNITED STATES		6c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. CITY OR TOWN OF DEATH HAGERSTOWN		7b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL		7c. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
8a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		8b. COUNTY WASHINGTON		8c. CITY OR TOWN HANCOCK	
9a. FATHER'S NAME FIRST MIDDLE LAST SAMUEL HUFFMAN		9b. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLENDELLA GANT		9c. STREET ADDRESS / ZIP CODE 121 PENNA. AVENUE 21750	
10a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		10b. SOCIAL SECURITY NO. 218 24 9989		10c. INFORMANT FRANKLIN SHIVES	
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic CVB</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4100</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>years</i> <i>years</i>			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Cardiac failure, Kidney failure</i>					
12a. DATE OF OPERATION <i>14 Sept 1977</i>		12b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>date</i>		12c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		13b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		13c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 13b. PART 1 OR PART 2)	
14a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		14b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		14c. LOCATION STREET CITY OR TOWN COUNTY STATE	
15. I certify that (I) (this hospital) attended the deceased from <i>14 Sept 1977</i> to <i>date</i> 19 <i>84</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) state the true cause of death.					
16. SIGNATURE <i>Richard T. Birtford</i>				16b. DATE SIGNED	
16c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard T. Birtford</i>				16d. ADDRESS <i>Hagerstown, Md</i>	
17a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		17b. DATE 4/13/1984		17c. NAME OF CEMETERY OR CREMATORY DAMASCUS CEMETERY	
17d. FUNERAL DIRECTOR NAME <i>Richard Shives</i>		17e. ADDRESS <i>Hancock MD</i>		17f. DATE REC'D. BY REGISTRAR APR 17 1984	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nan Crist Slicker			2a. DATE OF DEATH MONTH DAY YEAR 4 2 84		2b. HOUR 10:40 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 23 1901	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 1 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Ulysses Grant Miller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Belle Crist		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-14-7973	17. INFORMANT ADDRESS Williamsport, Md. Virginia L. Rouse 26 E. Potomac st.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 4100	DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days
Causes, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) Atherosclerotic cardiovascular disease	
	(c) Disease	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION 3/16/84	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right leg gangrene	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/16/84 to 4/2/84, that (I) (we) lost saw the deceased alive on 4/1/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE [Signature]	DEGREE MD	ATTENDING PHYSICIAN	22c. DATE SIGNED 4/4/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. S. U. MD	22e. ADDRESS 201 S. Cleveland Av. Hagerstown, Md.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-4-84	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland		25a. DATE REC'D. BY REGISTRAR APR 12 1984	
		25b. REGISTRAR'S SIGNATURE Julia Faidon-Robert	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Olivia Mae Slusher</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 27 84</i>		2b. HOUR <i>11:15P</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH DAY MONTH YEAR <i>August 25, 1888</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>95</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Warfordsburg, Pa.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housekeeper</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. CITY OR TOWN <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas Ruryan Slusher</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Ellen Peck</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>179-30-3955</i>		17. INFORMANT ADDRESS <i>Charles T. Slusher, 18 Millington Rd. Pleasant Ridge, Mich.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular episode</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic atrial fibrillation</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>0</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>4/27 1984</i> to <i>4/27 1984</i> , that (I) (we) last saw the deceased alive on <i>4/27 1984</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R.L. Kugler</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>4/28/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.L. Kugler</i>		22e. ADDRESS <i>100 Geeting Lane Keedysville, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal- Burial</i>		23b. DATE <i>4-30-84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sideling Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Needmore, Fulton Co., Pa.</i>
24. FUNERAL DIRECTOR <i>John H. Bast, Jr.</i>		ADDRESS <i>Boonsboro, Md. 21713</i>		DATE RECD. BY REGISTRAR <i>MAY 1 1984</i>	
				25. REGISTRAR'S SIGNATURE <i>Julia Swanson-Randall</i>	

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9/27/1919

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) <i>Christopher Charles Smith</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>4 5 1984</i>		2b. HOUR <i>8:35 AM</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 3 1967</i>	6. AGE (IN YEARS) (LAST BIRTHDAY) <i>17</i> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>4 5 1984</i>		2d. HOUR <i>9:10 AM</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Student</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Hi School</i>		
13a. STATE <i>Maryland</i>			13b. CITY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>Rt. 2 Box 105</i> <i>21740</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Vincent Patrick Smith</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Carolyn Jennette Andrews</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)			17. INFORMANT ADDRESS <i>Carolyn J. Smith Same as #13</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushing injury chest (N862) & multiple</i> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>Traumatic injuries (N869)</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>Motor vehicle - vehicle collision (E812)</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8:35 P.M. 4 5 1984</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Auto accident</i>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Street</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>US40 West of Hagerstown MD</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Allen W. Ditts</i>			TITLE (SPECIFY) <i>Det Asst</i>			DATE SIGNED <i>4/5/84</i>			MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <i>Allen W Ditts M.D.</i>			ADDRESS <i>1610 Oak Hill Ave Hagerstown MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>4-9-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Lawn Mem. Pk.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown Wash. Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Gerald N. Minnich Hagerstown, Maryland</i>			305 N. Potomac St.			25a. DATE REC'D. BY REGISTRAR <i>APR 12 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Quisenberry</i>		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmer H. Stevens, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 04-11-84		2b. HOUR 4:50 P.M.		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-19-1917		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Pennsylvania Franklin Waynesboro		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 948 Hawker Ave 17268			
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Harrison Stevens, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Jane Maun		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 205-01-6673	
17. INFORMANT ADDRESS Patricia Paull, R.D. #1, Biglerville, PA.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) fractoccephal fracture DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17307			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/11, 1984 , to 4/11, 1984 , that (I) (we) last saw the deceased alive on 4/10, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John R. Marsh, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R. MARSH, M.D.		22e. ADDRESS 239 N. POTOMAC STREET HAGERSTOWN, MD 21740		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/14/84	
23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro, Franklin, PA.		24. FUNERAL DIRECTOR NAME ADDRESS John S. Snyder, Jr., Waynesboro, PA.		25a. DATE REC'D. BY REGISTRAR APR 17 1984	
25b. REGISTRAR'S SIGNATURE John S. Snyder, Jr.							



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JAN 11 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

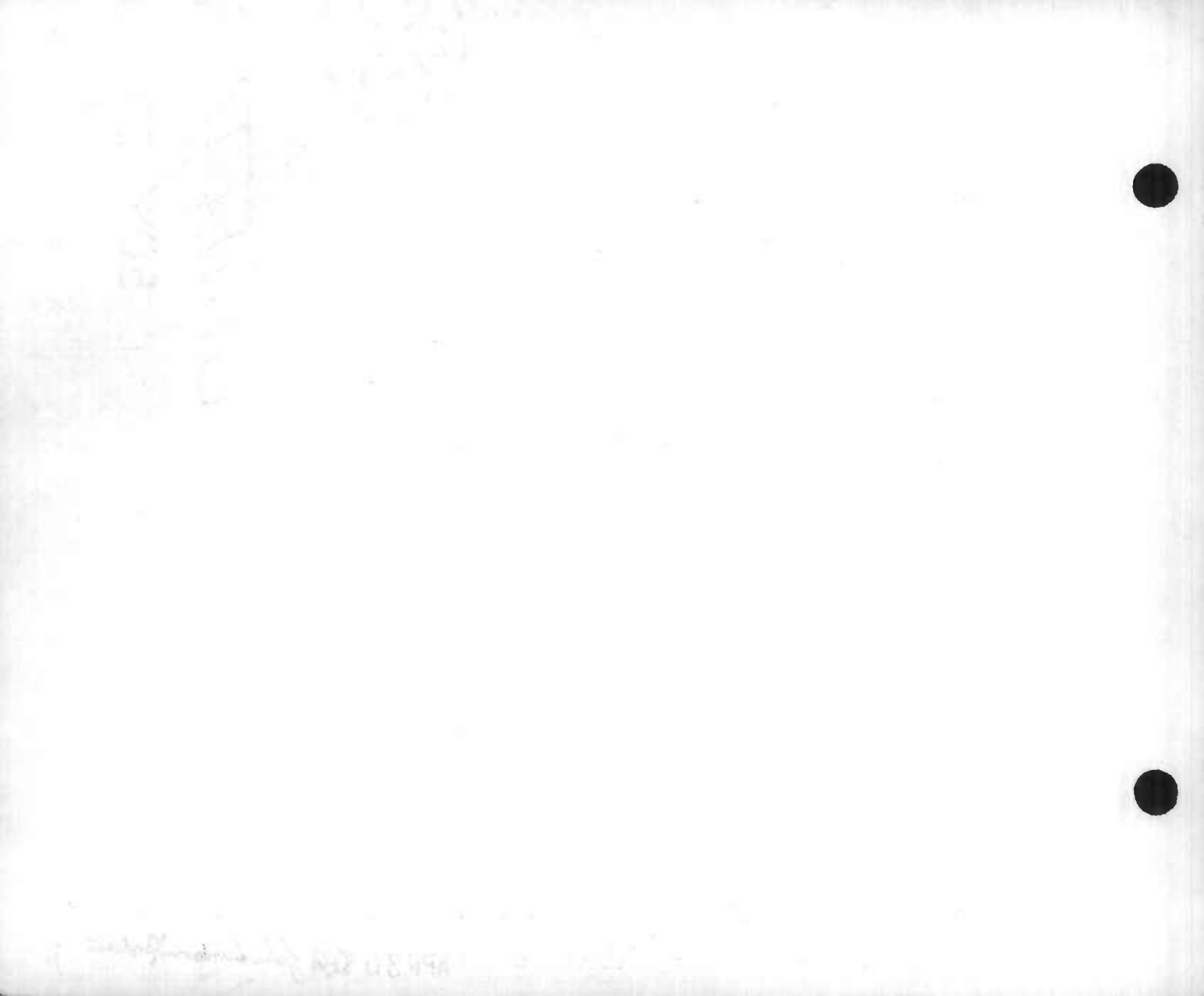
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1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Martha Frances Stine</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 24 84</i>			7b. HOUR <i>4:50 PM</i>	
3. SEX <i>F</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 16 04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Hagerstown, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>labor</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>shoe factory</i>		13a. STATE <i>Md.</i>		13b. COUNTY <i>Wash.</i>		13c. CITY OR TOWN <i>Hagerstown</i>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1814 Potomac Towers 21740</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>William E. Leiter</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Minnie Keller</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-09-1100</i>		17. INFORMANT ADDRESS <i>Helen Berger, Hagerstown, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4280 IMMEDIATE CAUSE (a) Cardiorespiratory arrest</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>COPD</i>							<i>several yrs</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>CHF</i>							<i>few years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/16</i> , 19 <i>84</i> , to <i>4/24</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>4/24</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Massoud B. Alizadeh</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4/24/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. MASSOUD B. ALIZADEH,</i>				22e. ADDRESS <i>363 S. Cleveland Ave. Hagerstown, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>4-27-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Md.</i>	
24. FUNERAL DIRECTOR'S NAME <i>MINNICH FUNERAL HOME</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 30 1984</i>			
25b. ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>				25c. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

BP



SEE CERTIFICATE NUMBER 84-34941

Bertie Rae Stotler - Wash.Co.--4/28/84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove column pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 1 8 7 7

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William DANIEL STOTLER			2a. DATE OF DEATH APR 15 1984 July 16 1926 3:55 PM		
3. SEX M	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR July 16 1926	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY Washington Co. Sch.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY Washington 13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 1052 Georgia Ave 21740		
14. FATHER'S NAME FIRST MIDDLE LAST William K. STOTLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HESTER DWYLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. World War II		17. INFORMANT ADDRESS Lloyd STOTLER - Brother.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper Gastrointestinal Hemorrhage 5713 DUE TO, OR AS A CONSEQUENCE OF (b) Bleeding Esophageal Varices DUE TO, OR AS A CONSEQUENCE OF (c) Advanced alcoholic liver disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 3-30 1984 to 4-5 1984, that (I) (we) last saw the deceased alive on 4-5 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE MD		DEGREE		22c. DATE SIGNED 4-5-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/9/84		23c. NAME OF CEMETERY OR CREMATORY broadfording Ch.	
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash. Md.		24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hag. Md. 21740			
25a. DATE REC'D. BY REGISTRAR APR 12 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodwell			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Alice STOTTLEMYER			2a. DATE OF DEATH MONTH DAY YEAR April 23, 1984		2b. HOUR 10 ³⁵ AM
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Feb. 3, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Ridenour		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Gossard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-5462		17. INFORMANT ADDRESS Charles L. Stottlemeyer, Hagerstown,	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Mo. <u>Mo.</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic CHF</u>		<u>Months</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>AFIB</u>		<u>Yrs</u>

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Senile Dementia, Dehydration</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-22</u> , 19 <u>84</u> , to <u>4-22</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4-22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>W. B. [Signature]</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-23-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W. B. [Signature]</u>		22e. ADDRESS <u>1933 1/2 Ave. Hagerstown, Md.</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Apr. 25, 1984	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.
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24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	25a. DATE REC'D. BY REGISTRAR APR 25 1984	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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1

TO THE DIRECTOR GENERAL
OFFICE OF THE
TREASURY DEPARTMENT
WASHINGTON, D.C.

FROM THE DIRECTOR GENERAL
OFFICE OF THE
TREASURY DEPARTMENT
WASHINGTON, D.C.

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

BY: [illegible]

FOR: [illegible]

BY: [illegible]

FOR: [illegible]

BY: [illegible]

FOR: [illegible]

BY: [illegible]

FOR: [illegible]

BY: [illegible]

FOR: [illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Earl L. Stultz			2a. DATE OF DEATH MONTH DAY YEAR 4 4 84		2b. HOUR 4:40 PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 18 05		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY FAIRCHILD
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE CITY OR TOWN W. Va. BERKLEY Falling Waters			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. BOX 81 99999
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH A. STULTZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE I COFFELT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-5636		17. INFORMANT ADDRESS Leona V. Stultz Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma of prostate gland 1850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-2, 19 84, to 4-4, 19 84, that (I) (we) last saw the deceased alive on 4-4, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE William G. Plavcan MD		DEGREE MD		22c. DATE SIGNED 4-4-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM G. PLAVCAN		22e. ADDRESS 1198 LENOX AVE HAGERSTOWN, MD. 21740			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 4/5/84	23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CREM.	23d. LOCATION CITY OR TOWN COUNTY STATE SMITHSBURG WASH MD.
24. FUNERAL DIRECTOR REST HAVEN FUNERAL CHAPEL 1601 Pennsylvania Ave. Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR APR 12 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 4 may be retained by the medical examiner.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the 72 hours statement with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Goldie Pearl Suder			2a. DATE OF DEATH MONTH DAY YEAR 4 17 1984			2b. HOUR 7:30 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 16 07		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash Co Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RFD-2 21740	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Graham					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Bishop				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-74-0436		17. INFORMANT ADDRESS Mrs. Mary Douglas Hancock Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 17, 19 84</u> to <u>April 17, 19 84</u> , that (I) (we) lost saw the deceased alive on <u>April 17, 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dino J Delaportas				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DINO J DELAPORTAS MD				22e. ADDRESS 703 OAK HILL AVE, HAGERSTOWN, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 20, 84		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md	
24. FUNERAL DIRECTOR Thompson Funeral Home				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 25 1984			

at 1.15/20
much 11 1/2

1875

1875
1875

1875 1875 1875

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST KATHERINE		MIDDLE DAVIS		LAST SUMMERS		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH March 15, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Libertytown, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington, MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Libertytown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12120 Main Street 21762			
14. FATHER'S NAME FIRST MIDDLE LAST Roy Gardner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genevieve Davis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-03-4547		17. INFORMANT ADDRESS Mr. Thomas E. Joy 8396 Discovery Pl. Walkersville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. 4280 IMMEDIATE CAUSE (a) Cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) Crystalline heart failure	
DUE TO, OR AS A CONSEQUENCE OF										(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 4/1/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM WATKINS, MD		22e. ADDRESS 1600 DAK HILL AVE. HAG. MD 21740									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/21/84		23c. NAME OF CEMETERY OR CREMATORY Fairmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Libertytown, Frederick, Md.					
24. FUNERAL HOME (TYPE OR PRINT) R. E. Dailley & Son, Inc.		25a. DATE REC'D. BY REGISTRAR APR 25 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodella							

BP. _____

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APR 28 1964
Faint handwritten text

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH ANNA LOUISE SWISHER				APRIL 4, 1984			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 15, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1363 Salem Ave..		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER		12b. KIND OF BUSINESS OR INDUSTRY FACTORY	
13a. STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES FRANKLIN BOHN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST URSULA BLANCHE GROSSNICKLE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-09-7165	
17. INFORMANT FIRST MIDDLE LAST JUDY HERBIGH		ADDRESS Box 244I Hedgesville, WVa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1042
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>67</u> to <u>4/4</u> 19 <u>84</u> , that (we) lost <u>know the deceased alive on 3/18/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Robert V. Campbell MD</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>4/11/84</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robt V. Campbell</u>	
22e. ADDRESS <u>Hagerstown Md</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/7/84		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.	
24. FUNERAL DIRECTOR REST HAVEN FUNERAL CHAPEL, INC. 1601 Pennsylvania Ave. Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR <u>APR 12 1984</u> 25b. REGISTRAR'S SIGNATURE <u>J. A. Davidson</u>			

BP

1

WASHINGTON, D.C. 20540
U.S. DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D.C. 20540
ATTENTION: ADJUTANT GENERAL
WASHINGTON, D.C. 20540
U.S. DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D.C. 20540
ATTENTION: ADJUTANT GENERAL
WASHINGTON, D.C. 20540

WASHINGTON, D.C. 20540
U.S. DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D.C. 20540
ATTENTION: ADJUTANT GENERAL
WASHINGTON, D.C. 20540
U.S. DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D.C. 20540
ATTENTION: ADJUTANT GENERAL
WASHINGTON, D.C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) Russell H. Thomas			MONTH APR DAY 1 YEAR 1984			8:25 4 M		
3 SEX Male	4 RACE WHITE	5. DATE OF BIRTH MONTH Oct. DAY 9 YEAR 1908	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.					
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer-Lab.		12b. KIND OF BUSINESS OR INDUSTRY Truck		
13a. STATE Hagerstown			13b. COUNTY Washington	13c. CITY OR TOWN Maryland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 209 Green Valley Drive 21740
14. FATHER'S NAME FIRST Abraham MIDDLE David LAST Thomas			15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE LAST LaBar					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 150-03-5985A		17. INFORMANT Edith C. Thomas Same as #13			ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL CARCINOMATOSIS * 1629 DUE TO, OR AS A CONSEQUENCE OF (b) IN LUNGS AND ABDOMEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) FROM CARCINOMA SIGMOID COLON							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1982	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION 2/19/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA SIGMOID COLON			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NONE				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NONE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 				
22a. I certify that (I) (this hospital) attended the deceased from FEB 81 to APR 1 84 , that (I) (we) last saw the deceased alive on APR 1 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Francisco G. Japzon MD					22c. DATE SIGNED 4/1/84		DEGREE MD	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCISCO G. JAPZON MD					22e. ADDRESS 645 E. FIRST ST HAGERSTOWN MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-4-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Pk.		23d. LOCATION CITY OR TOWN Hagerstown COUNTY Wash. STATE Md.		
24. FUNERAL DIRECTOR NAME Gerald N. Minnich ADDRESS Hagerstown, Maryland				25a. DATE REC'D. BY REGISTRAR APR 12 1984		25b. REGISTRAR'S SIGNATURE John T. ...		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified in detail.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 1 8 8 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Grace Letitia Thompson				2a. DATE OF DEATH MONTH DAY YEAR April 30, 1984			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND		13b. COUNTY WASH.		13c. CITY OR TOWN BOONESBORO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN C. WIMMER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LETITIA SHANNON		13e. STREET ADDRESS 141 S. Main St. 21713			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-50-9431		17. INFORMANT ADDRESS Letitia Short 2118 Va. Ave. Hagg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hour years							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Milaninia M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MILANINIA M.D.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/3/84		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN WASH. MD.	
24. FUNERAL DIRECTOR REST HAVEN FUNERAL CHAPEL, INC. 1601 Pennsylvania Ave. Hagerstown, Md				25a. DATE REC'D. BY REGISTRAR MAY 7 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson Rodes			

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CHIEF MAN

20% COTTON

MAY 1957

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>William H. Thompson</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 4 29 1984			2b. HOUR <i>Unknown</i>		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 10 1906</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>77 YRS.</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>4 30 1984</i>	2d. HOUR <i>9P</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD		
10. CITY OR TOWN OF DEATH <i>Hancock</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Residence - 119 W. Main St.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Salesman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Sales</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hancock</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>119 W. Main Street</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Homer G. Thompson</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Unknown</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>236-14-2177</i>		17. INFORMANT ADDRESS <i>Charles Thompson 1921 Nevill Rd. Baltimore, MD 21222</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4292 IMMEDIATE CAUSE (a) Atherosclerosis, cardiovascular disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>429</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>Alcoholism 303</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Allen W. Dittus MD</i>			TITLE (SPECIFY) <i>Dist Asst</i> M.D.			DATE SIGNED <i>5/1/84</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>Allen W. Dittus MD</i>			ADDRESS <i>1610 Oak Hill Dr. Hyattsville MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>May 3, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Martinsburg WV</i>		
24. FUNERAL DIRECTOR NAME <i>Charles M. Brown</i>				ADDRESS <i>327 W. King St. Brown Funeral Home PO Box 821, Martinsburg, WV</i>		DATE RECEIVED <i>MAY 11 1984</i>		



RECEIVED 21 JAN

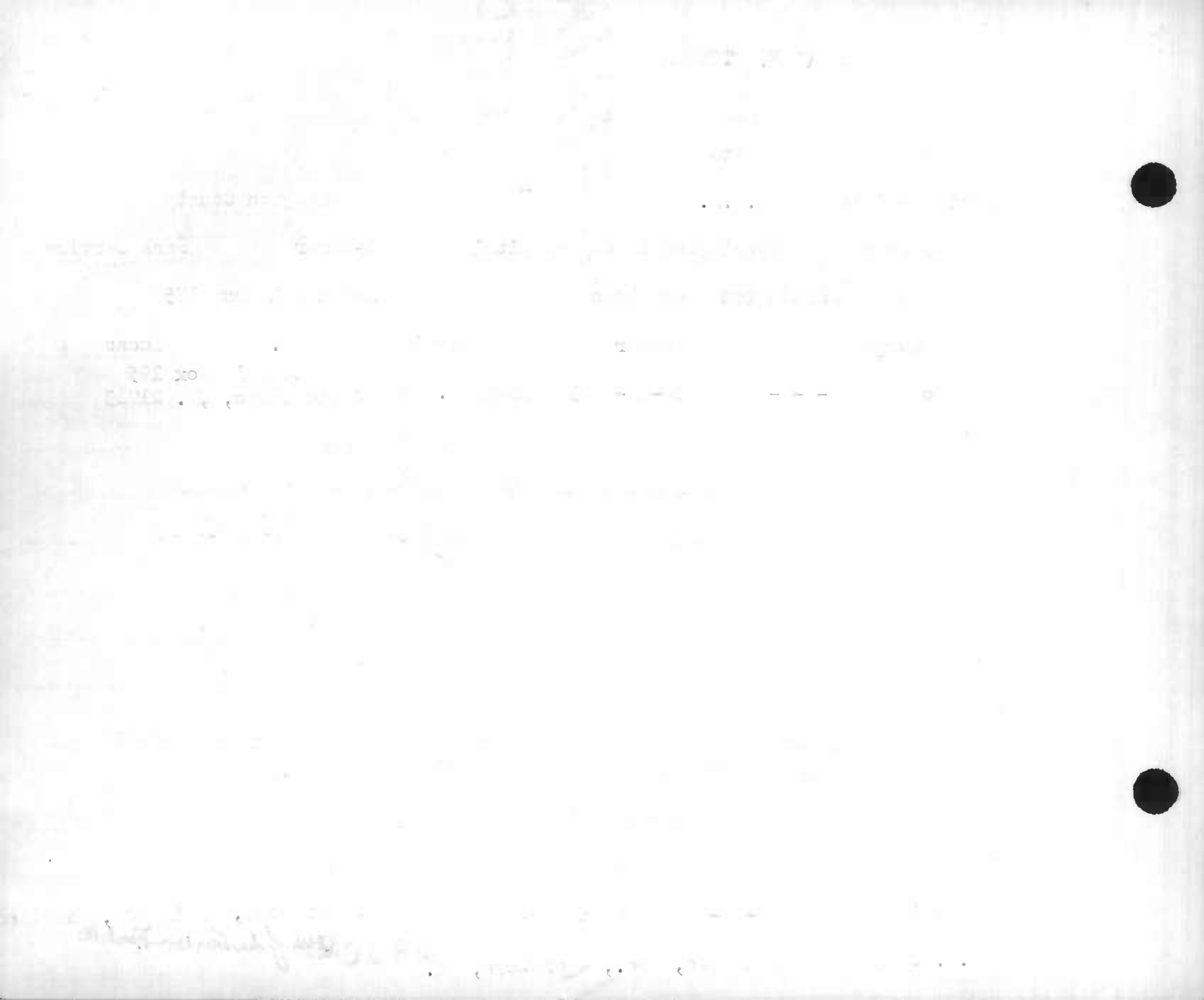
SEE CERTIFICATE NUMBER 84-34942

Harold Clinton Trovinger - Wash., 4/29/84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the attending physician and completely filled in by the funeral director, who should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

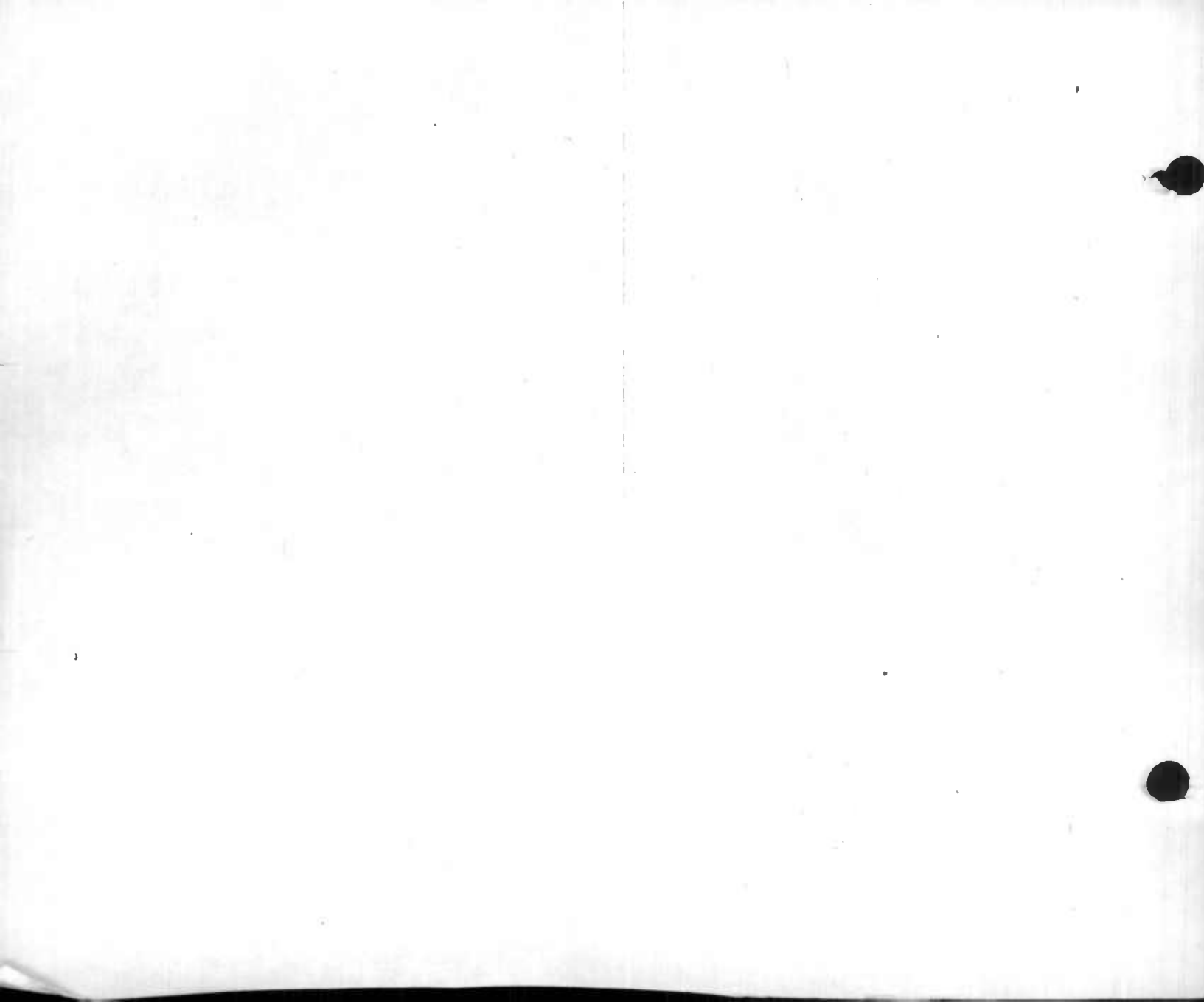
IMPORTANT: If item 21 is marked "other," it should be filled in above any injury, or other traumatic event, while medical attention was being rendered at any place.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. STATE REGISTRAR HERMAN (NMN) TURNER					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) HERMAN TURNER					2a. DATE OF DEATH MONTH DAY YEAR 4 23 84			2b. HOUR 6:45 PM	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 7 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Park Service	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13e. STREET ADDRESS / ZIP CODE Route # 1 Box 195 21740			
14. FATHER'S NAME FIRST MIDDLE LAST George Turner					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie E. Lucas				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-14-6003		17. INFORMANT ADDRESS Route # 1 Box 195 Boonsboro, Md. 21713 Lorena G. Turner					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Severe generalized arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/4 , 19 84 , to 4/23 , 19 84 , that (I) (we) last saw the deceased alive on 4/23 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John R. Marsh, M.D.					DEGREE M.D.			22c. DATE SIGNED 4/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R. MARSH, M.D.					22e. ADDRESS 239 N. POTOMAC ST. HAGERSTOWN, MD. 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-27-84		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Maryland		
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md.					25. DATE REC'D BY REGISTRAR APR 30 1984				



See Certificate number 84-34943

Thomas Richard Wade -- Wash.Co. -- 4/22/84



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Alice Marjorie Walling			2a. DATE OF DEATH MONTH DAY YEAR 4 8 1984		2b. HOUR 11:30 P M
3. SEX Female	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR Dec. 29, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	7. UNDER 1 YEAR MONTHS DAYS 84
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Smithsburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 19 Blue Mt. Estates 21783	
14. FATHER'S NAME FIRST MIDDLE LAST John C. Steele		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena Hill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 142-22-2289		17. INFORMANT ADDRESS Mrs. Evelyn A. Cables Smithsburg, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

METASTATIC CARCINOMA, I⁰ UNDETERMINEDAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**6 mo**1991
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

none

19a. DATE OF OPERATION		19b. DURATION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from Jan 10 19 83 to 4-8 19 84 , that (I) (we) last saw the deceased alive on 4/8 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE ME Byrkit		DEGREE		22c. DATE SIGNED 4-10-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ME Byrkit		22e. ADDRESS 28 W Potomac Williamsport Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE April 10, 1984	23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Wash, Md.
24. FUNERAL DIRECTOR NAME Davis ADDRESS Smithsburg, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 11 1984	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sadie Lucille Walsh</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 17 84</i>			2b. HOUR <i>135 p.m.</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 25 98</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Colton Villa Nursing Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <i>46 Red Oak Dr.</i>		13f. CITY OR TOWN <i>21740</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>Levi Rand</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elinora Weaver</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>201-16-7572A</i>		17. INFORMANT ADDRESS <i>Frances Trump, Hagerstown, Md.</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> <i>4280</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Angiogram heart failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) lost <i>saw the deceased alive on</i> <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Abdul Wattedan</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4/19/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <i>1600 Oak Hill Ave. Hgt. MD 21740</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>Apr. 23, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park, Inc. St. Petersburg, Fla.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
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24. FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME</i> <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 23 1984</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR ELLEN BULLARD WAREHAM CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Ellen Bullard Wareham						2a. DATE OF DEATH MONTH April DAY 28 YEAR 1984		2b. HOUR 8:50 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH May DAY 8 YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeder Memorial Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1334 Potomac Avenue	
14. FATHER'S NAME Frank		15. MOTHER'S MAIDEN NAME Ellen		16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-16-1882-D		17. INFORMANT Mary Ellen Kline ADDRESS Route # 4 Box 454-85 Martinsburg, W. Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4275 Cardio Pulmonary Arrest IMMEDIATE CAUSE (a) 4275 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. L. Kugler		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-28-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. L. Kugler		22e. ADDRESS Keedysville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-2-84		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN Hagerstown, Washington, Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc., Hagerstown, Md. ADDRESS MAY 3 1984 Julia Davidson-Randall									
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE									

MEDICAL CERTIFICATION

1. The first group of people who are not allowed to enter the country are those who are not citizens of the United States.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Richard Donovan WASSON			2a. DATE OF DEATH MONTH DAY YEAR April 15, 1984			2b. HOUR M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 13, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 312 S. Mulberry Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) shoe company	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Funkstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Earl Wasson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Wakenight			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea		17. INFORMANT ADDRESS Mrs. Elizabeth McCall, Hagerstown, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1991

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

3/15/83

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Mass in abdomen

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (the hospital) attended the deceased from 3/15 19 84 to 4/15 19 84, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

Thomas V. Craig

DEGREE

MD

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

4/17/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

239 N. Potomac. Hagerstown, Md 2176

23a. BURIAL, CREMATION, REMOVAL

burial

23b. DATE

Apr. 18, 1984

23c. NAME OF CEMETERY OR CREMATORY

Rest Haven Cemetery

23d. LOCATION

Hagerstown, Wash., Maryland

24. FUNERAL DIRECTOR

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

25a. DATE REC'D. BY REGISTRAR

PR 19 1984

REGISTRAR'S SIGNATURE

Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72-hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

A

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Theodore Watson			2a. DATE OF DEATH MONTH DAY YEAR 4-25-84		2b. HOUR 10:28 M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7-3-1906	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wash. Co. MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 316 Henry Ave. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Watson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary NMN Minor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 225-01-4591		17. INFORMANT ADDRESS Mildred Owens 352 Henry Ave. Hag.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Leiomyosarcoma of Stomach**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 1/2 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

liver metastases from leiomyosarcoma.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from Jan 19 80 , to April 25 19 84 , that (b) (we) lost saw the deceased alive on 4/25 19 84 , and that in (c) (my) opinion death occurred on the date and hour and from the causes stated above. Richard E. Smith (did not view the body after death).			
22b. SIGNATURE Richard E. Smith, M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/25/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.		22e. ADDRESS 1708 Oak Hill Ave Hagerstown, Md.	

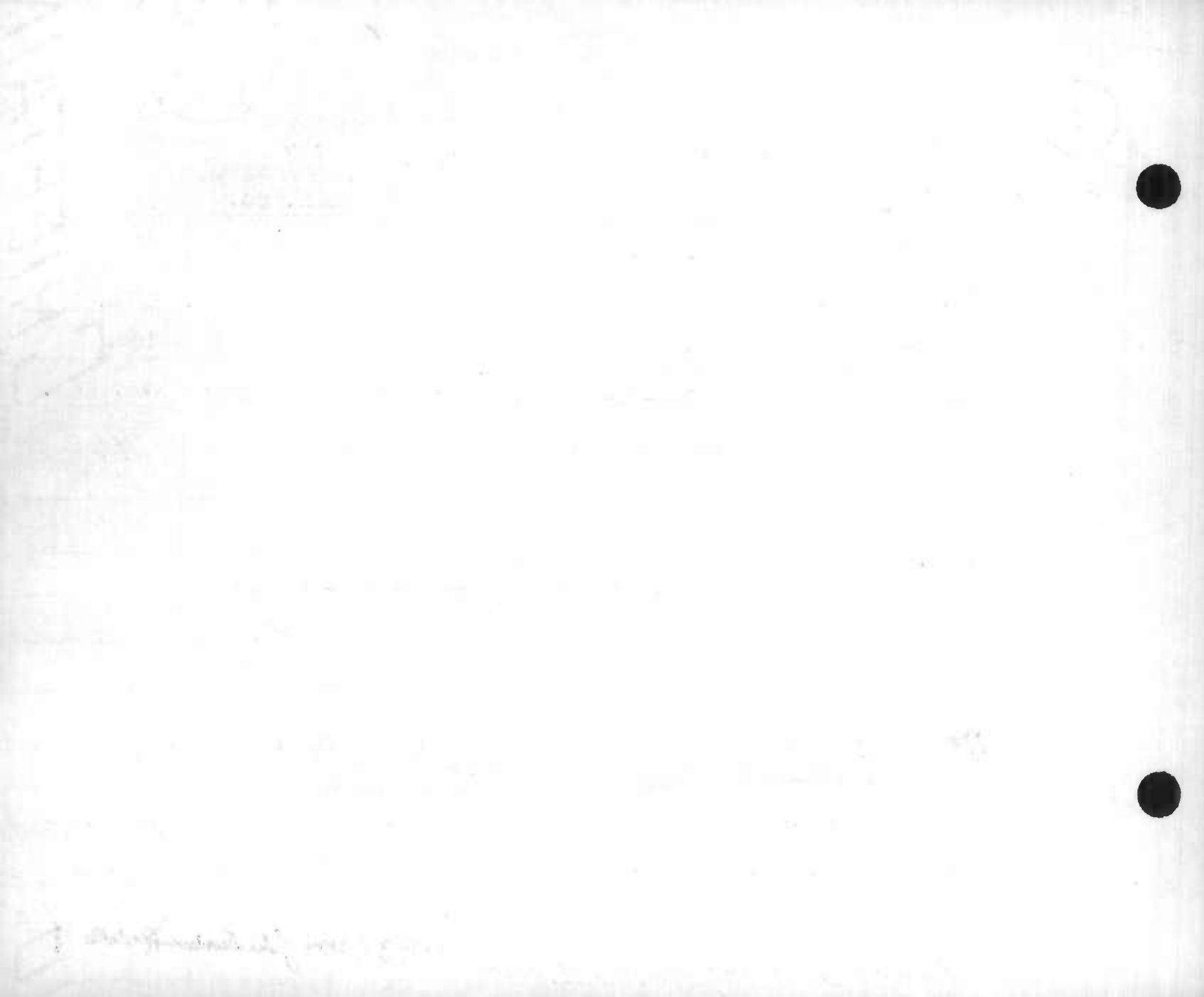
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/29/84	23c. NAME OF CEMETERY OR CREMATORY Newtown Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Harrisonburg/Rock'nham Va.
24. FUNERAL DIRECTOR NAME ADDRESS Dennis L. Davis Smithburg, Md.		25. DATE RECEIVED BY DISTRICT HEALTH OFFICER APR 30 1984	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death certificate should be notified.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KENNETH WILLIAM WELLER			2a. DATE OF DEATH MONTH 4 DAY 4 YEAR 1984 2b. HOUR 10:05pm	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH March DAY 4 YEAR 1929	6. AGE (IN YEARS LAST BIRTHDAY) 55	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY railroad
13a. STATE Maryland	13b. COUNTY Wash.	13c. CITY OR TOWN Maugansville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 468 Weaver Ave. 21767
14. FATHER'S NAME FIRST Clarence MIDDLE Albert LAST Weller		15. MOTHER'S MAIDEN NAME FIRST Elsie MIDDLE A. LAST Kendall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-20-4057	17. INFORMANT ADDRESS Geraldine V. Weller, Maugansville, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Arrest 2503 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Renal Failure (c) Diabetic Nephropathy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate years years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Congestive Heart Failure**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/3 19 84 to 4/4 19 84 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 4/4 19 84 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.			
22b. SIGNATURE Rose Marie Chan M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/4/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROSE MARIE CHAN		22e. ADDRESS Western Maryland Center Hagerstown	

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE Apr. 7, 1984	23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park	23d. LOCATION CITY OR TOWN Hagerstown COUNTY MD ZIP 21740
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a. DATE REC'D. BY REGISTRAR APR 6 1984 REGISTRAR'S SIGNATURE Jana Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified by the funeral director.

BP

DHMM - 16 50M 4/B2
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 84 11893	
1. DECEASED NAME (TYPE OR PRINT) Anna Pauline Wiles						2a. DATE OF DEATH MONTH DAY YEAR April 2 1984			2b. HOUR M		
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 4 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1 Box 181 Clearspring, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Clearspring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1 Box 181 21722			
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Richard Rubeck						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Ann Wiley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-48-2831		17. INFORMANT ADDRESS Gary E. Wiles Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 2506 DUE TO, OR AS A CONSEQUENCE OF (b) with congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus - severe peripheral vascular disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) the hospital attended the deceased from 12 19 78 to 4 19 84, that (1) was lost saw the deceased alive on 37 19 84, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, if (did not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Eric M. Wagshal, M.D.						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-4-84			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 4-5-84		23c. NAME OF CEMETERY OR CREMATORY Blairs Valley Ch. of God Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Blairs Valley Md.	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland						25a. DATE REC'D. BY REGISTRAR APR 12 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson			

MEDICAL CERTIFICATION



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John R. Winters			2a. DATE OF DEATH MONTH DAY YEAR 04-05-84			2b. HOUR 1040 P.M.			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 / 04 / 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (CITY OR TOWN) Baltimore		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
12. CITY OR TOWN OF DEATH Hagerstown		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Middletown			17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			18. STREET ADDRESS / ZIP CODE 8612 Reno Monument Rd. 21769			
19. FATHER'S NAME FIRST MIDDLE LAST John P. Winters			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Abbie Richardson			21. ADDRESS 8612 Reno Monument Rd. Middletown, Md.			
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO			23. SOCIAL SECURITY NO. 579-60-0898			24. INFORMANT Mrs. Charlotte L. Winters			
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2859 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) severe anaemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
26. DATE OF OPERATION			27. CONDITION FOR WHICH OPERATION WAS PERFORMED			28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
33. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			35. LOCATION STREET CITY OR TOWN COUNTY STATE			
36. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
37. SIGNATURE [Signature] DEGREE MD						38. DATE SIGNED 4/6/84			
39. PHYSICIAN'S NAME (TYPE OR PRINT) Abdul W. Hattar						40. ADDRESS 1600 Oak Hill Ave. Hager, MD 21740			
41. BURIAL, CREMATION, REMOVAL Burial			42. DATE 4-9-84			43. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery			
44. FUNERAL DIRECTOR (NAME) John H. Bast, Jr.			45. ADDRESS Boonsboro, Md. 21713			46. DATE REC'D. BY REGISTRAR APR 11 1984			
47. REGISTRAR'S SIGNATURE [Signature]			48. REGISTRAR'S SIGNATURE [Signature]						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Betty Louise WIVELL</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>APRIL 28 1984</i>		2b. HOUR MIN. <i>5:05 P.M.</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>JUNE 08 1935</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>48</i>		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 1 YEAR HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Western Maryland Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY <i>Maryland Frederick</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George R Pittinger</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ella V. Eyler</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>214-32-2545</i>		17. INFORMANT ADDRESS <i>Bernard R. Wivell, 9511 Appolds Rd. Rocky Ridge Md. 21778</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> <i>4280</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>less than 24 hrs.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>ASThromboma GII frontal lobe</i>					
19a. DATE OF OPERATION <i>April 26 1984</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Decompression</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION CITY OR TOWN STREET <i>HAGERSTOWN</i>		21g. COUNTY <i>Frederick</i>		21h. STATE <i>Md.</i>	
22a. I certify that (X) (this hospital) attended the deceased from <i>December 15, 1983</i> to <i>April 28, 1984</i> , that X (we) last saw the deceased alive on <i>April 26, 1984</i> , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.					
22b. SIGNATURE <i>FE U. Porciuncula</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>April 28/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>FE U. PORCIUNCULA</i>		22e. ADDRESS <i>1500 PENNSYLVANIA AVE. HAGERSTOWN MD 21740</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1 May 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Emmitsburg Memorial</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Emmitsburg, Frederick, Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>skiles Funeral Home, Emmitsburg, Md. 21727</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FANNIE GENEVIEVE WOLF			2a. DATE OF DEATH MONTH DAY YEAR 4 27 1984		2b. HOUR 6:05 AM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 - 28 - 1988		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 95		
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AVALON MANOR		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.		
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		
14. FATHER'S NAME FIRST MIDDLE LAST Eavey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Ridenour		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-28-6615		17. INFORMANT ADDRESS Dorothy E. Smallwood 26 South Mulberry St. Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of (Left) Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yr						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from June 19 63 , to 27 April 19 84 , that (I) (we) last saw the deceased alive on 24 April 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE W. N. Feeder				22c. DATE SIGNED 4.27.84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. N. Feeder				22e. ADDRESS 138 E Antietam St. Hagerstown Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-30-84		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, I. c.,		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Washington, Md.		25a. DATE REC'D. BY REGISTRAR MAY 3 1984		
				25b. REGISTRAR'S SIGNATURE John Davidson-Rodell		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		3. DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		20. DATE KNOWN OF DEATH ESTI-MATED		26. HOUR	
LOREINE				ZIMMERMAN		<input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR		M	
LORI		(NMN)				4 7 19 84			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE IN YEARS		7. IF UNDER 1 YR. IF UNDER 24 HRS.	
Female		White		April 22, 1968		15 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		24. HOUR	
Maryland		U.S.A.				Washington County		10:30 a.m.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Nr. Boonsboro		Reno Monument Rd. e. of Md. Rt. 67		Student		High School			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Washington		Hagerstown				820 Concord Street 21740	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Edward Franklin Zimmerman		Sandra Lorraine Long		No		217-82-1335		Sandra L. Long	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18a. IMMEDIATE CAUSE (a)		18b. DUE TO, OR AS A CONSEQUENCE OF		18c. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
9630		Asphyxia							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 4-7- 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		path on		Reno Monument Rd. e. of Md. Rt. 67, Wash. Co. Md.					
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 4-15-84	
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		23e. COUNTY	
Burial		4-18-84		Rose Hill Cemetery		Hagerstown		Washington	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. STATE	
A.K. Coffman Funeral Home, Inc.,		Hagerstown, Md.		APR 1 9 1984		John A. Dixon		Maryland	

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